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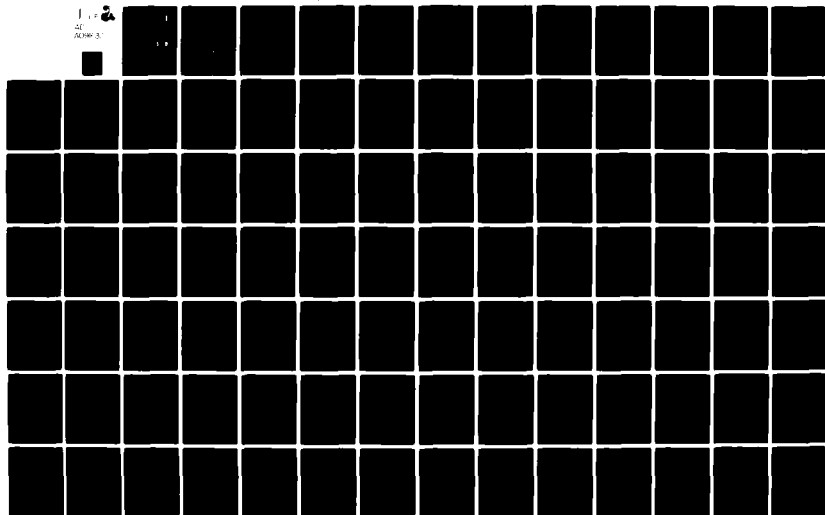
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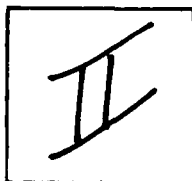
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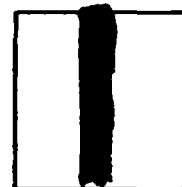
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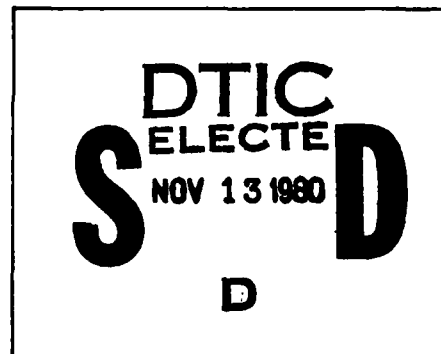
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**A HANDBOOK
FOR ALCOHOL AND DRUG CONTROL OFFICERS
VOLUME I**

AD A091632

SOCIAL PROCESSES TECHNICAL AREA
INDIVIDUAL TRAINING & PERFORMANCE RESEARCH LABORATORY

February 1975



U. S. Army

Research Institute for the Behavioral and Social Sciences

in cooperation with Arthur D. Little, Inc.

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**U. S. ARMY RESEARCH INSTITUTE
FOR THE BEHAVIORAL AND SOCIAL SCIENCES**

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DRAFT

**A HANDBOOK
FOR ALCOHOL AND DRUG CONTROL OFFICERS
VOLUME I**

SOCIAL PROCESSES TECHNICAL AREA

INDIVIDUAL TRAINING & PERFORMANCE RESEARCH LABORATORY

February 1975

This draft handbook has been developed for use by Alcohol and Drug Control Officers in the U.S. Army. The information included in this draft handbook, however, should not be taken as reflecting the official policies or doctrines of the U.S. Army with regard to the prevention, identification, treatment or rehabilitation of drug and alcohol users.

U. S. ARMY RESEARCH INSTITUTE FOR THE BEHAVIORAL AND SOCIAL SCIENCES

**Office, Deputy Chief of Staff for Personnel
Department of the Army
1300 Wilson Boulevard, Arlington, Virginia 22209**

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Institutional Change

In cooperation with Arthur D. Little, Inc.

MANAGING ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAMS:

A HANDBOOK FOR

ALCOHOL AND DRUG CONTROL OFFICERS

A Report to the

United States Army Research Institute
for the Behavioral and Social Sciences

February 1975

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I. THE PROBLEM

Over the last ten years, Americans have slowly and painfully come to realize that illicit drug use and problem drinking are widespread among people in all walks of life. Gradually we have learned that the misuse of drugs and alcohol is a very complex social and individual phenomenon, by no means limited to failures or malcontents at society's fringe. It potentially affects virtually every home and place of business--and every barracks--in which Americans live and work. Wherever it occurs it proves to be extremely difficult to handle; it is a puzzle which has defeated many of those who have tried to solve it. In order to understand how it affects the Army, let us first look at available estimates of how much drug use and problem drinking there is among Army personnel. These statistics do not show that the problem is caused by Army life, but they do show that it is a real and serious problem for the Army just as it is for the rest of society.

A. ALCOHOL

An estimated nine million Americans are problem drinkers,¹ and the military apparently has at least its share of the problem. A problem drinker is defined here as someone whose drinking has caused adverse consequences in his personal life (problems with family or others, job difficulty, accidents, arrests, etc.) one or more times within a period of three years.

1. Footnote numbers in this chapter refer to the references listed in Section E.

- It has been estimated² that in the Army 44% of junior enlisted men, 27% of senior enlisted men, 18% of junior officers, and 13% of senior officers are problem drinkers.
- Only about 5000 men are currently participating in the Army's alcohol rehabilitation program,³ clearly leaving large numbers of personnel with drinking problems which are not being treated.
- A survey⁴ showed that in 1972-73 28% of the junior enlisted men had increased their consumption of alcohol since entering the Army, while only 21% had decreased it.

B. MARIJUANA

Since the late 1960s, the use of marijuana has spread rapidly, especially among the young. It is estimated⁵ that as many as 22% of all adult male Americans and 40-50% of all male high school and college students have tried marijuana at one time or another. Initially most prevalent and visible among university students on the east and west coasts, marijuana use is now decreasing in this group after gaining wide acceptance in other youth subcultures. It has become common among high school students with a variety of class and educational backgrounds in many parts of the country,⁶ and it continues to spread to other geographic regions and even younger age groups. In other words, marijuana is widely used throughout the population from which the Army draws its recruits. Thus, as in the case of alcohol, many soldiers have already started using marijuana by the time they begin Army service. What is the extent of their marijuana use in the Army?

A survey⁴ of more than 1600 junior enlisted men (E-1 to E-5) carried out from October 1972 to February 1973 in the Army reveals that:

- About 53% of all junior enlisted men in the Army said they currently (i.e., in the last two months) used marijuana, and approximately 40% used it at least once a week.
- Use is by far the most common among younger soldiers.
- Fifty-seven percent had used marijuana at some point in their lives.
- Of those who used marijuana, 31% said that they had begun their use after entering the Army. (Of course, in many cases, this is because they reached the age when they would have begun anyway.)

In a study carried out in 1971,⁷ 16% of Army enlisted men (including senior NCOs) reported that they had used marijuana on the job. About 45% had seen it so used. Thus, while there is as yet no definitive research proving or disproving that marijuana and hashish have long-term harmful physiological or psychological effects on users, it does appear that their use is costly to the Army in terms of lowering performance on the job.

C. OTHER DRUGS

Now that a number of the Army personnel who became heroin users while serving in Vietnam either have been processed out of the service or else have overcome this habit on their own following their return to the United States, the attention devoted to heroin has decreased.

However, the 1972-73 study cited above⁴ shows that heroin use in the Army continues at a low level of prevalence. This will probably remain the case so long as drug use continues in American society. The study also found the following:

- About 8% of the junior enlisted men in the Army reported they were currently (in the last 60 days) using heroin, though only 3% used it at least weekly. Other narcotics were currently used by 18%, with 8% using them at least weekly.
- About 17% of Army junior enlisted personnel had used heroin at some time in their lives. About 24% had used some other narcotic.
- More than half of the heroin users began their use after joining the Army. One third of those who had used another narcotic began their use in the Army.

The following statistics are available on illegal use of other substances, such as hallucinogens, stimulants, and depressants, among Army enlisted men:

- The 1972-73 survey found that between 19% and 30% of the Army's junior enlisted men were currently (last two months) using one or more of these drugs.⁴
- At least a third of the junior enlisted men had used one or more of these drugs at some time in their lives.⁴
- Between a quarter and a third of the users of these drugs began their use after entering the Army.⁴

- Another survey found that about 12% of the Army's enlisted men used drugs other than marijuana on the job at least occasionally. (This statistic probably includes some use of opiates.) More than a third had seen these drugs used on the job.⁷

D. THE PROBLEM FOR THE ARMY AND THE ADCO's TASK

Thus, there is considerable problem drinking and illicit drug use in the Army. Many junior enlisted men bring drug use with them when they enter the service, and some change their drug use patterns while in the Army as they come in contact with the drug subculture among fellow soldiers. The evidence of drug use on the job and the known effects of problem drinking on job performance indicate that these practices directly impair military efficiency by reducing the availability and capabilities of some personnel at all levels of rank. Other effects are less direct. For instance, the leadership structure must devote an unduly large share of its time to disciplining or providing for treatment of the individuals involved. Also, some observers believe that the concentration of drug use among younger soldiers has hurt the Army by creating increased distance and mistrust between junior and senior personnel. They feel that this, combined with associated differences in life style, tends to foster disrespect on the part of the junior men and intolerance on the part of senior men.

Surveys of individual Army installations show that the alcohol and drug problem and effective solutions can vary greatly. For example, the 1972-73 survey, which covered 16 different Army posts,⁴ revealed that

even within the continental United States the percentage of E-1s to E-5s using marijuana within a 60-day period ranged from 42% to 67% at different posts. At these same posts, the proportion of men who said that alcohol and drug education had influenced them to reduce their drug use ranged from 7% to 28%. Social research on drug-using groups⁶ has also revealed that the drug subculture which supports and spreads drug use is by no means uniform and that its membership and motivations depend greatly on local conditions. All of this suggests that the Army's Alcohol and Drug Abuse Prevention and Control Programs need to be tailored locally to meet specific local conditions. This handbook deals with the role of the Alcohol and Drug Control Officer and his staff in carrying out that task.

E. REFERENCES

Following are the sources of statistics quoted in this chapter. These are valuable reading for anyone interested in developing further understanding of the alcohol and drug problem.

1. US Department of Health, Education, and Welfare, First Special Report to the US Congress on Alcohol and Health (Washington, DC: US Government Printing Office, 1971).
2. Don Cahalan, Ira A. Cisin, Geoffrey L. Gardner, and Gorman C. Smith, Drinking Practices and Problems in the US Army (Information Concepts Incorporated, 1972)
3. Dr. Richard S. Wilbur, former Assistant Secretary of Defense (Health and Environment), in a prepared statement before the Senate Subcommittee on Drug Abuse in the Military Services, during the Subcommittee's hearings on September 18, 19, and 20, 1973, on a "Review of Military Drug and Alcohol Problems."

4. R. F. Cook and A. S. Morton, An Assessment of Drug Education/Prevention Programs in the US Army, Technical Paper 271 of the US Army Research Institute for the Behavioral and Social Sciences (Washington, DC, January 1975).
5. National Commission on Marijuana and Drug Abuse, Drug Use in America: Problem in Perspective (Washington, DC: US Government Printing Office, 1973).
6. Schwartz, Turner, Peluso, "Neither Heads nor Freaks, A Working Class Drug Subculture," Urban Life and Culture (October 1973).
7. A. H. Fisher, Preliminary Findings from the 1971 DOD Survey of Drug Use (Alexandria, Virginia: Human Resources Research Organization, 1972).

II. WHY THIS HANDBOOK?

- *This handbook is a guide to managing the ADAPCP at an Army post.*
- *It describes management as the repeated process of answering the following questions:*
 - *What do we want to accomplish?*
 - *How should we do it?*
 - *What is actually being done?*
 - *What have we accomplished?*
 - *How can we improve?*
- *It suggests methods of obtaining the information needed to answer each of the above for the ADAPCP.*
- *It stresses the importance to managers of asking the right questions and obtaining the right information.*
- *It stresses continual improvement of the information base and refinement of the questions as the management cycle is repeated.*

These days, every service and function in the Army is being scrutinized for ways to conserve resources and the Alcohol and Drug Abuse Prevention and Control Programs are no exception. Also, many ADAPCPs were launched at a time of crisis and did not receive the systematic planning that could later provide the basis for evaluation and improvement. These programs now need careful and skilled management to ensure both efficient resource use and maximum effectiveness.

This handbook is a guide to program management for use by the Alcohol and Drug Control Officer (ADCO) and his staff at an Army post. It discusses the five basic questions that the management process should answer and suggests ways of obtaining the information needed to answer them for the installation's ADAPCP.

A. THE MANAGEMENT PROCESS

In order to accomplish its purpose with available manpower and funds, the ADAPCP needs clearly defined objectives, careful allocation of resources to objectives, and systematic monitoring of both program activities and results to permit timely adjustments. The ADCO and his staff need to make the following decisions:

1. What do we want to accomplish? Given the Army's statement of mission for alcohol and drug programs, and given the particular situation at this installation, what should be the specific goals and objectives of this program? What is their order of priority? How can they be defined so that program staff and others whose cooperation is needed all understand what the program is designed to achieve and recognize whether it is succeeding?
2. How should we do it? Once the desired results have been defined, what combination of available strategies will best achieve these results?
3. What is actually being done? There are two parts to this question. First, are chosen strategies being implemented as planned? Second, what procedures are being followed by those people and agencies outside the ADCO's

jurisdiction who have responsibilities relating to the alcohol and drug problem?

4. What have we accomplished? How well has the program achieved its objectives? How can its achievements be demonstrated, both to people on the installation and to higher authority?
5. How can we improve? In the light of program objectives, strategies, and results, what changes should be made for the next year? How can requests for more resources be justified?

As illustrated in Figure 1, these decisions make up a continuous, cyclic process. As experience is gained with the program, objectives are constantly clarified and strategies changed to make it work better. At each stage, the handbook emphasizes asking the right questions-- identifying the information needed for sound program decisions and then requesting that information clearly so that what is received is complete and in a useful form. Figure 1 shows some of the points at which new information enters the management process.

Even with the best information, program decisions may not always be the right ones. Society is still learning about the alcohol and drug problem, and no one has yet found a sure solution. However, by continuing to ask the right questions, ADAPCP staff can gain an increasingly clear view of what is working and what needs to be changed.

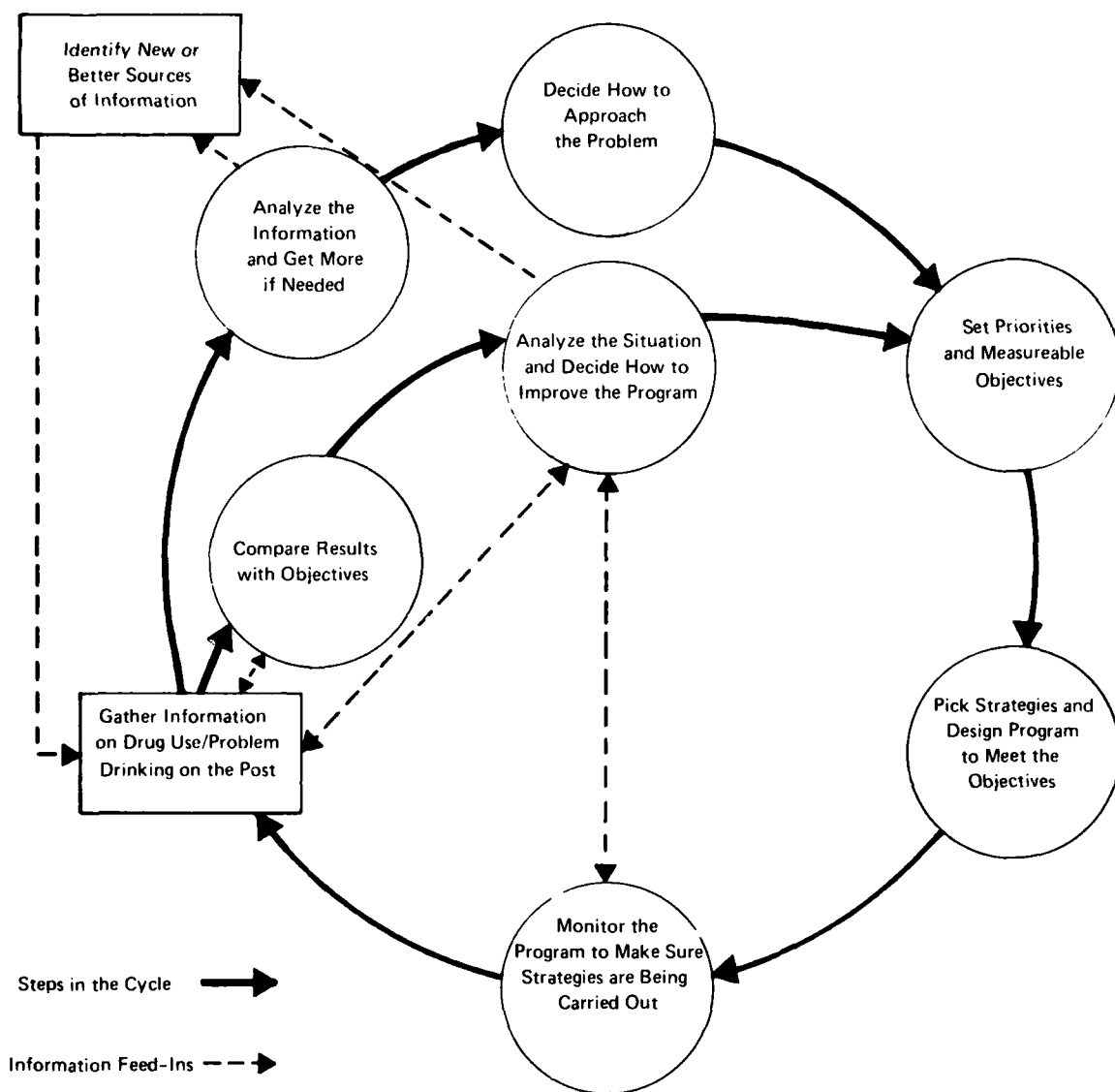


FIGURE 1 THE MANAGEMENT CYCLE

B. A GUIDE TO THIS HANDBOOK

The handbook is organized around the above five questions. The management steps outlined are designed to be carried out by program staff, either with or without the aid of specialists. Accompanying the handbook is a book of appendices providing detailed guidance for obtaining management information, with questionnaires and other data gathering instruments that can be used or adapted for use in each program. If program staff ask and answer the five questions, take action on the basis of the answers, and continue asking the questions in order to improve the actions taken, the program will be both efficiently and effectively managed.

Throughout the handbook, the term drug use refers to all illicit use of drugs, and the term problem drinking to drinking which causes problems for the individual or the command, whether or not the individual could be defined as an alcoholic. The term substance abuse refers to drug use and/or problem drinking.

C. REFERENCES ON MANAGEMENT

The following list has been selectively compiled to provide managers of Army alcohol and drug programs with a variety of points of view on management and with a resource for use in finding approaches to management problems. Particularly recommended are the items marked with asterisks.

Bass, Bernard M., Current Perspectives for Managing Organizations

(Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1970).

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*Odiorne, George S., Management by Objectives (New York: Pitman Publishing Corp., 1965).

Rausch, Edward N., Principles of Office Administration (Columbus, Ohio: Charles E. Merrill Publishing Co., 1964).

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Valentine, Raymond F., Performance Objectives for Managers (New York: American Management Association, 1966).

III. WHAT DO WE WANT TO ACCOMPLISH?

- *What is the nature and extent of the alcohol and drug problem on this post?*
 - *Is it viewed primarily as a problem of illegal behavior? Of lowered mission capability? Of human costs?*
 - *What do known statistics on drug use and problem drinking suggest about their prevalence on this post?*
 - *What information, specific to this post concerning prevalence, substances and population groups involved, and substance abuse patterns and motivations, can be obtained from interviews with personnel on the post and from summaries of post records?*
 - *Is further information needed that is best obtained through anonymous sample surveys of confirmed or potential substance abusers or of the leadership structure?*
- *What are the target substances, target populations, and program components of highest priority for the ADAPCP?*
- *What are the results objectives of the ADAPCP?*

The general goals that the ADAPCP must try to meet are stated in Department of the Army publications. DA policy provides that commanders are to institute the following activities:

- Prevention of alcohol and drug abuse, to include both education and law enforcement.
- Identification of alcohol and drug abusers.
- Treatment, rehabilitation, and counseling for identified alcohol and drug abusers, to include detoxification for those who need it.
- Program evaluation.
- Research.

The Army also states objectives for these activities and suggests approaches for the ADAPCP. However, these objectives and approaches are deliberately presented in relatively general terms. Within these guidelines, each installation's Commanding Officer is responsible for deciding, on the basis of the local situation, what emphasis and priorities will be set among the objectives, and for structuring program staffing and other allocations of resources in the best way to achieve them.

A. DEFINING THE PROBLEM FOR THE POST

In order to set specific objectives and priorities for the ADAPCP, the post CO, the ADCO, and the program staff need a clear picture of the problem to be solved, based on information that is as complete and accurate as possible concerning the alcohol and drug situation on the post: which substances are a problem on the post and what kinds of

undesirable effects they are creating, what kinds of people are using drugs or drinking excessively, and--as a guide to developing strategies for reducing the amount of substance abuse--why people on the post do use drugs or drink too much. The ADCO and his staff will typically act as the CO's agents in obtaining this information.

Another part of defining the problem is deciding why the post needs a drug and alcohol program in the first place. Is it because drug use and problem drinking lower the mission capability of the units on the installation? Is it because drugs are illegal? Is it because of an interest in protecting individuals from harmful effects of alcohol and drugs? Which reason or combination of reasons will set the guidelines for the program? That is, which effects of substance abuse is the program most concerned with avoiding? These are major strategic policy decisions, and they should be made or approved by the CO.

Throughout the process of defining the problem and, later, setting specific objectives, ADAPCP staff may find that the Alcohol and Drug Dependency Intervention Council (ADDIC) provides a useful sounding board and discussion place. The ADDIC membership typically includes unit commanders, who often will have valuable insights about the problem and ideas concerning program priorities. (The role of the ADDIC is considered in more detail in Chapter IV.)

The next section describes some ways of obtaining information on drug use and problem drinking on the post. Sections C and D discuss how this information can be used in establishing program objectives.

B. ESTIMATING THE EXTENT OF THE PROBLEM

To make sure that the ADAPCP is focused on the right objectives, and to determine how well it is achieving these objectives, program staff will need to measure the installation's alcohol and drug problem not just once but on an ongoing, continuous basis. This usually implies some formal measurement at least every year. Therefore, during the information gathering process, it is advisable to make arrangements that will facilitate gathering the same kinds of information in the future. By looking at changes from one year to the next, ADAPCP staff will be able to (1) discern new problems involving alcohol and drugs on the post which call for changes in program objectives, and (2) see where the program seems to be working and where it may need improvement. This chapter discusses the first of these tasks, and Chapters VI and VII discuss the second.

1. Using Population Statistics

The simplest way to estimate the size of the alcohol and drug problem on the post is to obtain population statistics on rates of substance abuse and to multiply these rates by the number of people on the post. The rates used might be those for the US population aged 18 through 25 in order to obtain as close a match as possible with the population of the post, or else available statistics for the Army could be used. Statistics cited in Chapter I of this manual can be used for this purpose.

The best that can be achieved with these statistical approaches, however, is a "ballpark" figure indicating the probable number of

individuals on any post who are drug users or problem drinkers. This can be helpful, but it is not nearly as useful as information describing the population of a specific post. The ADAPCP will probably be most effective if it is aimed at well-defined targets--the population groups and substances that are of concern on a particular installation. Once these targets are known, program objectives can be established around them and the program carefully focused where the problem is. There are a number of ways to obtain information specific to the post, some relatively easy and others more sophisticated but also more reliable. The easier ones are described first, since these provide a good general picture of what is happening. The more difficult approaches discussed next may provide valuable additional detail on certain aspects of the problem.

2. Interviewing People and Examining Post Records

A large portion of the information needed can probably be obtained through interviews with people on the post. A checklist of the people to talk with might include the following:

- ADAPCP personnel;
- drug users and problem drinkers, past and present;
- law enforcement officials (MP, CID, and off-post);
- medical activity staff, especially psychiatrists;
- members of the leadership structure and of the ADDIC;
- chaplains; and
- managers of enlisted men's, NCOs', and officers' clubs and chiefs of service agencies.

In the process of learning what these people have to say about the problem, the ADCO or his representative can also find out about record-keeping procedures--who keeps records, where they can be found, and what information they contain. While certain individual records are confidential, summaries are not, and summaries of the following could be especially useful:

- arrest records;
- disciplinary proceedings;
- rehabilitation cases;
- operational readiness failures; and
- cases coming to the attention of the medical activity.

Summaries of law enforcement records, for example, may provide information on increases and decreases in drug and alcohol abuse as well as on the types of drugs that are presently most in use. Summaries of health records will include some of the same information, together with information on referrals to the ADAPCP for particular types of service, as a possible guide to setting program emphasis.

Besides providing first-hand knowledge of what other personnel on the post think about the alcohol and drug problem, together with useful data based on records, these visits and discussions can help the ADCO and his staff to accomplish the following:

- Familiarize themselves more closely with all aspects of the post's operations and leadership structure.
- Establish communication links between the ADAPCP and law enforcement officials on and off the post, chaplains,

medical staff, and other persons whom the substance abuser is likely to encounter as a result of his abuse.

- Set up a regular information gathering process, including personal contacts and structured instruments such as questionnaires, that can be used in the future to reassess the problem and identify new objectives.
- Establish the groundwork for later assessment of program results.

The program staff's understanding of post operations and contacts with the leadership and with medical, law enforcement, and other personnel will also help enlist support and cooperation that can greatly enhance the effectiveness of the program.

Suggested below are some questions that might be asked during the interviews. Once as much information as possible has been obtained from available statistics, interviews, and summaries of post records, program staff can decide whether they need the more detailed and exact information that could be obtained from one or more questionnaire surveys, as discussed in Section 3.

a. Questions to Ask ADAPCP Staff

By asking the same questions of many sources, comparing the answers, and probing apparent discrepancies, the ADCO can get a sense of the accuracy of the information and the reliability of different sources. It can sometimes be especially useful to compare the information received from ADAPCP staff with findings from elsewhere. Where there is conflicting information, an exploration of the differences could reveal

that program staff are out of touch with some aspects of the problem and that improved communications are needed between the ADAPCP and the rest of the post.

The ADCO will naturally develop his own list of questions to review with his staff. The following are offered as examples:

- How available are various drugs on the post?
- Which substances are abused most? What kinds of people are abusing them?
- How do drug users first come in contact with drugs before or during military service, and under what circumstances?
- For what reason(s) do persons stop using drugs or drinking excessively?
- Are soldiers aware of the ADAPCP? What are their attitudes toward it?
- How is each unit coping with substance abuse?
- What should be the major areas of emphasis for the ADAPCP on this post? Why?

b. Questions to Ask Substance Abusers

One way to learn about the use patterns, attitudes, and motivations of drug users and problem drinkers is to interview them. Yet, it can be difficult to obtain accurate information from these individuals, especially if their substance abuse has not been confirmed. They need assurance that the interviewer and the program he represents are concerned about their needs and problems, that the interviews are strictly

confidential, and that nothing will happen to them as a result of anything they say. Once some rapport is established, substance abusers often turn out to be glad of the opportunity to discuss their abuse and its consequences in the military.

Questions might focus on how much alcohol and drug usage there is on the post, how available drugs are, why people are or were substance abusers, and what has happened to them in the Army as a result. Possible questions include:

- How available are drugs on the post? What kinds?
- Which drugs are easily obtained in the surrounding community?
- How did you first come to use drugs/alcohol?
- Why did/do you use them here?
- How is alcohol abuse or drug usage generally handled by your unit?
- Have you stopped using certain drugs? Why?
- Have you ever received a disciplinary action due to drug usage?
- What could the alcohol and drug program be doing better?

Appendix A provides more detailed guidance for talking with drug users and problem drinkers, together with sample interview forms.

c. Questions to Ask Law Enforcement Officials

Law enforcement agencies and the ADAPCP have some common objectives and activities. These include preventing problem drinking and drug use, and identifying problem drinkers and drug users. Although their objectives

are similar, some of their functions, and especially the way those functions are perceived by people on the post, are different. People tend to perceive law enforcement agencies as related to disciplinary and legal action against substance abusers. The ADAPCP is, on the other hand, perceived as using treatment and other nonpunitive measures to cope with deviant behavior. Thus, too close an association between the ADAPCP and law enforcement officials could create some mistrust of the former. Nevertheless, ADAPCP and law enforcement have information that it is important they share, especially concerning the kinds of drugs presently used, new drugs on the scene, and other factual data on drug use.

Pertinent questions to raise with law enforcement officials include:

- In what cooperative ways can ADAPCP and law enforcement personnel work together?
- In which unit(s) is alcohol abuse and drug use most common?
- What type of working relationship/information exchange does your agency have with local community law enforcement officials?
- Are any informal guidelines used by the agency in handling possession of marijuana by military personnel?
- What drugs are easily obtained on and off the post?
- What kinds of statistical information does your agency keep? What records can be made available to the ADCO?

Appendix B discusses interviews with law enforcement officials in more detail.

d. Questions to Ask Medical Activity Staff (MEDDAC)

Mutual cooperation and exchange of information between the alcohol and drug program and the post's medical services are important to the effort to identify and provide treatment to the alcohol or drug abuser. With good coordination, considerable duplication of effort may be avoided. Some questions to ask the medical activity staff include:

- How much of your time is utilized in the care of alcohol and drug related cases?
- How many patients do you see monthly for reasons related to alcohol and drugs?
- What services do you provide to substance abusers by medical personnel?
- What are your procedures for clinical confirmation of drug use?
- What are your procedures for referring a confirmed drug abuser to the ADAPCP?
- What are the most common substance abuse problems treated? How and where are the records on these kept? How can appropriate information be made available to the ADCO?
- What are the medical implications of drug use and problem drinking on the post?

e. Questions to Ask the Leadership Structure

Line officers and NCOs in the chain of command have more daily contact with the soldier than law enforcement, ADAPCP, or medical personnel have. They have more influence on his experience of military

life and on his everyday behavior. They also feel most directly the effects of alcohol and drug abuse on unit operational readiness. These questions seem to be relevant:

- How do you identify most substance abusers?
- How many of the people in your command are presently using drugs? Drinking too much? On or off duty?
What kinds of drugs?
- For what reasons do men in your unit use drugs or drink too much?
- How can the ADAPCP assist you?
- How much of your time is spent in dealing with alcohol and drug related matters?
- What is the impact of drug use and problem drinking on operational readiness in your unit?
- Do you feel you need some special training or information to deal with alcohol and drug users and the alcohol and drug problem?

Appendix C provides further guidance on talking with the leadership structure.

Talks with ADDIC members may be especially useful. Since the ADDIC advises the CO on the development and coordination of alcohol and drug abuse prevention and control, it is important that program staff be aware of its members' assessment of needs and problems related to drugs and alcohol. Also, the staff's own assessment of the level of awareness of the leadership structure could be an important guide to setting attainable objectives.

f. Questions to Ask People in
Service Agencies and Recreation Facilities

Chaplains, managers of officers', NCOs', and EM clubs, and staff of the Red Cross, Army Community Services, Mental Health Clinics, and recreation facilities may be able to provide useful perspectives on the off-duty life and concerns of military personnel and on the effects of alcohol and drugs. The following questions may be applicable:

- How many people do you see who appear to be using drugs or drinking excessively?
- How available are drugs on the post? What kinds are most frequently seen?
- What reasons have you found for substance abuse among service people?
- How do you handle drug users and problem drinkers when you come in contact with them?
- Do you think there are needs for different or additional services or types of assistance for drug users and problem drinkers?
- What effects do you think present Army efforts to control drugs and alcohol have had on substance abuse?
- What do you think the ADAPCP should be doing for substance abusers?

3. Anonymous Sample Surveys

Anonymous surveys can give you very useful information on the amounts and kinds of drug use and problem drinking on the post and on the needs of substance abusers. The ADAPCP can conduct such surveys with guidance from Appendix D, preferably with the assistance of someone experienced in survey research.

Anonymous surveys have several advantages. A written questionnaire can be completed by a much larger number of people than could be interviewed in an equivalent amount of time, and the assured confidentiality makes it more reliable than interviews for such purposes as determining how much unconfirmed substance abuse there is. Also, the items in a questionnaire can be structured to permit many kinds of cross-tabulation of the results, either manually or by computer. For example, one can cross-tabulate drug or alcohol habits and attitudes with such factors as race, pay grade, Army status and length of service, and feelings about the Army to obtain a picture of the types of people who show attitudes and use patterns of concern.

Three groups of people, or populations, could be surveyed:

- (1) Potential substance abusers; that is, people who have not been confirmed as drug users or problem drinkers, but who might be.
- (2) Confirmed abusers.
- (3) The leadership structure.

The first group, potential abusers, is different for drugs and for alcohol. For drugs, it generally consists of all lower-ranking enlisted men (those in pay grades E-1 through E-5) on the post who have not been confirmed as users. For alcohol, it includes everyone on the post who has not been confirmed. Anonymous surveys administered to carefully chosen samples of potential abusers can yield reliable estimates of how many people on the post are using drugs and drinking excessively, and can determine whether these problems tend to be concentrated in certain groups. They can reveal much about what the drugs of choice are, why people are using drugs or drinking too much, how and why their substance abuse began, whether it has increased on this installation, and what factors and circumstances would be likely to stop or reduce it.

A survey of the second population of interest, confirmed substance abusers, will not provide accurate information about the prevalence of substance abuse on the post,¹ but it will provide some information on the comparative popularity of different types of drugs, the reasons why people use drugs and drink too much, the functions which alcohol and drugs serve in their lives, and other characteristics, behavior, and attitudes of substance abusers. Further, a comparison of data obtained from the confirmed group with data from the general population (the potential substance abusers) may reveal some patterns of difference between abusers and the general population. From these, it may be possible

1. Information from confirmed users cannot be applied directly to the post population. There is no way to estimate prevalence of problem drinking or drug use on the post on the basis of data from those who have been confirmed. The latter are a highly selected sample; even their friends (if one were to ask them about prevalence among the people they know) constitute a biased sample.

to identify Army units where a high incidence of drug use or problem drinking may be expected or to identify life situations or background factors that are often accompanied by substance abuse.

Finally, a survey addressed to the leadership structure on the post can provide information about the attitudes of officers toward drug use and problem drinking, what they are doing about these problems, how well-informed they are on drugs and alcohol, and what training, education, or other kinds of support would enable them to cope with the substance abuse better at their various levels of command. The leadership structure can also be an additional source of information about prevalence of use. Finally, the survey can usefully include an open-ended question asking the respondent to indicate what he feels are the needs of the installation regarding alcohol abuse and problem drinking that the ADAPCP should try to meet.

C. SETTING TARGETS AND PROGRAM PRIORITIES

The information obtained about the alcohol and drug problem on the post can help in a number of ways to determine program objectives. First, it helps to show, at any given time, which are the target substances of highest priority. These are the substances to which the most time, energy, effort, or resources will be devoted in order to eliminate or cut down on their abuse. They may be chosen as targets on the basis of some combination of their prevalence with other criteria discussed above, such as their illegality, effect on mission accomplishment, or human costs.

Information on the alcohol and drug situation also helps in identifying high priority target groups. For example, if, contrary to conventional assumptions, drug use is found to be a significant problem among personnel aged 30 or over, there is reason to consider addressing part of the program specifically to this older population group. To take another example, if interviews or other data reveal that large supplies of heroin have suddenly become available, particularly to members of a transportation detachment at the post, again a possible priority target group has been identified. The nature of each target group can have implications for how, when, and where the ADAPCP conducts its education and identification efforts.

Finally, in some cases, information on the alcohol and drug situation will point to decisions about the priority of program components. It may indicate that a particular component (education or other prevention, identification, or treatment and rehabilitation) of the program deserves more resources or time than the other components. To conform with DA policy, the ADAPCP must maintain at least some activity in each component, but the CO is free to decide how much emphasis to put on each. Thus, if interviews with medical and law enforcement people indicate that drug use or problem drinking is widespread on the post, and yet few substance abusers have been confirmed, the identification component probably needs strengthening. If confirmed users of a certain drug report that the drug had much more serious effects than they had anticipated, there is an apparent need to strengthen the drug education program. If the number of confirmed substance abusers is found to be much larger than

can be accommodated at a given time in the post's treatment/rehabilitation program, there is an obvious need to increase the capacity of that program.

In the case of the education program, there is evidence that another decision needs to be made about priorities. This is whether the program will be aimed primarily at increasing knowledge about drugs and alcohol, at changing attitudes, or at changing behavior. Chapter IV treats this issue further in discussing education program strategies.

D. RESULTS OBJECTIVES AND PROCESS OBJECTIVES

Once a clear understanding of the problem has been reached and basic priorities established for the ADAPCP, two kinds of objectives can be defined: results objectives and process objectives. Process objectives are the subject of the next chapter. They describe specific program activities, and they make it possible later to monitor the program and ensure that it is being carried out as planned. They are most useful if stated operationally--that is, if they describe well-defined and quantified actions rather than broad goals. A process objective could state, for example, that each month 1000 people will receive two hours of alcohol and drug education with a specified content and message, provided by specified types of instructors and using specified media. The purpose is to state the objective in a way that permits a clear subsequent determination of whether the objective was met.

Before process objectives can be set, however, it is important to define what the ADAPCP will try to achieve. This means establishing objectives in terms of results. Again, operational statements are most

useful. For example, one of the desired results of the program might be to decrease the number of problem drinkers on the post. To convert this goal into a results objective requires specification of the amount of the decrease, and the criteria to be used both before and after the program to determine whether an individual is a problem drinker. The results objective might be:

To decrease from 100 to 50 the number of problem drinkers self-reported in an anonymous survey conducted at the beginning and end of the year.

Other examples of results objectives are:

- To increase knowledge about drugs so that 80%, rather than the present 50%, of the men in grades E-1 through E-5 on the post will be able to get a score of 80% or better on a particular test of knowledge about drugs.
- To increase from 25% to 50% the proportion of "graduates" of the treatment rehabilitation program who are judged by their immediate supervisors to be performing satisfactorily on the job three months after completing the program.

A more complete discussion of how to set results objectives, with additional examples, appears in Appendix E.

Note that the first step is to set results objectives. Then the ADCO and his staff decide what program activities are likely to achieve the results objectives. Then process objectives are established describing these activities. This step-by-step planning keeps the program carefully focused on the results it is intended to achieve.

By stating both results objectives and process objectives operationally, ADAPCP staff can ensure that they and all other concerned parties have a common understanding of the results desired and the activities specified. They can then see clearly whether or not the activities are being carried out properly and, later, how close the program came to the results. If the results were not achieved, the staff will have a firm basis for proposing improvements, and if they were achieved, the program's success can be clearly documented to superiors.

IV. HOW WILL WE ACCOMPLISH OUR OBJECTIVES?

- *What process objectives will be set to accomplish each results objective of the ADAPCP?*
 - *Are proposed process objectives feasible?*
 - *What specific work tasks will be set within each broad strategy chosen?*
- *What are the program's staffing requirements, and how will available resources be used?*
 - *How many positions are needed and what are their functional components?*
 - *What numbers and types of staff are available or authorized, both within the program and from other agencies and organizations?*
 - *What qualifications must program staff meet?*
 - *Which individual is best for each position?*
 - *How will requirements for additional staff be met?*
 - *What in-service training will staff receive?*
- *How can the ADCO make most effective use of the ADDIC?*
- *What is the role of MEDDAC staff in the program?*
- *How can alcohol and drug education be designed to avoid the pitfalls of many past efforts?*
- *How will the education program for each target group be structured in terms of:*
 - *Communicators?*

- *Messages?*
- *Media?*
- *The environment?*
- *The receiver?*
- *The destination?*
- *To what degree will the education program be centralized or decentralized?*
- *What other aspects of prevention will the ADAPCP seek to influence?*
 - *Improvements in the environment?*
 - *Performance of helping agencies?*
- *Can the system of identification and referrals be improved?*
 - *Is the ADAPCP properly organized to handle referrals?*
 - *What are the steps in the identification process, beginning with each possible referral source?*
 - *Which are the high-priority referral sources for improvement?*
- *What are the steps in the rehabilitation process?*
- *How will rehabilitation decisions be made?*
- *How will rehabilitation modalities be chosen?*
- *What use will the rehabilitation program make of the halfway house? Of significant others?*
- *What new modalities are needed, and how can the necessary skills be developed?*

Once results objectives have been specified, the next step in program management is to develop a program that appears to offer the highest assurance of successfully reaching each objective within existing constraints of manpower, time, money, and other resources. There are two aspects to this. One is specification of a program design--a set of process objectives describing the strategies and work tasks to be carried out to achieve the desired results. The other, interrelated with the first, is staffing and organization of the program.

A. SETTING PROCESS OBJECTIVES

As discussed earlier, a process objective is a very specific description of some action to be taken. It says what is going to be done to whom, over what time period, and using what resources.

1. Converting Results to Program Components

The starting point for developing process objectives is the set of results objectives that have emerged from a study of the alcohol and drug problem on the post, combined with various directives from higher authorities. For example, if interviews have revealed that commanders are not well enough informed about alcohol, drugs, and their responsibilities concerning substance abuse, results objectives might be set describing how much and in what respects their knowledge is to be improved, and to meet these objectives the ADCO and his staff might plan a training program for commanders (to whom).

In any case, however, the Army requires the ADAPCP to provide education for leaders. The task of the program, then, is to meet the

DA requirement in the ways that also best accomplish the desired results. What technical aspects of drugs should commanders understand? Should they be able to recognize different kinds of pill? Should they be able to state the effects of each of various drugs in technical terms, or is it sufficient for them to know, for example, that "downers" slow down vital body functions and make a person feel somewhat drunk? Sometimes it may be necessary to augment program objectives to meet requirements, but more often the requirements are stated broadly enough to allow the ADCO and his staff focus on what they consider most important.

Before results objectives can be translated into process objectives for the program, they generally need to be broken out into their components. For example, suppose commanders are to learn how to recognize drug users and problem drinkers. The next step is to identify everything that goes into the commanders' knowledge of how to recognize drug users and problem drinkers. The commanders should know that changes in a soldier's work performance and ability to get along with others on the job are sometimes indicators of problems and drugs and alcohol and that drug use or heavy drinking may cause a man to exhibit symptoms such as staggering, slurred speech, glassy eyes, or a characteristic odor. Once all the component information has been identified, it is possible to be specific about the content to be taught (what, discussed more later in this chapter) and how long it will take. Staff may conclude that they can teach what a commander needs to know in one hour and twenty minutes. By analyzing each results objective in this way, they can determine the total number of hours needed for the program.

Suppose that this process results in an overall program for commanders of 20 hours. If two instructors are to be used (using what resources) and each instructor devotes part of his time to administration and other activities, then each can go through the 20-hour program only once a week. If the available classroom will hold no more than thirty people and there are 175 commanders to be taught, it follows that 3 weeks are needed (over what time period) to complete the program. Thus, a broad process objective has been defined. More detailed process objectives will spell out the components of the program, down to the daily lesson plan which states the instructor's process objectives for a particular session.

2. Adjusting for Feasibility

At any stage in the planning, constraints may force a change in plans. For example, if the organization is to go on an extended maneuver beginning on the first of January, and the CO or other authority has specified that this training program must be completed prior to that event, and it is now the first of November, some adjustment in the objective must obviously be made. More instructors and space will have to be found, fewer subjects covered, or fewer commanders taught. Often, decisions like this may not be entirely up to program staff. If the objective has been set by higher authority, the staff cannot arbitrarily change it. As illustrated in Figure 2, it will be necessary to go back to the authority for a decision.

It should be evident by now what is meant by the statement that objective-setting is an "iterative" procedure. Each part of the

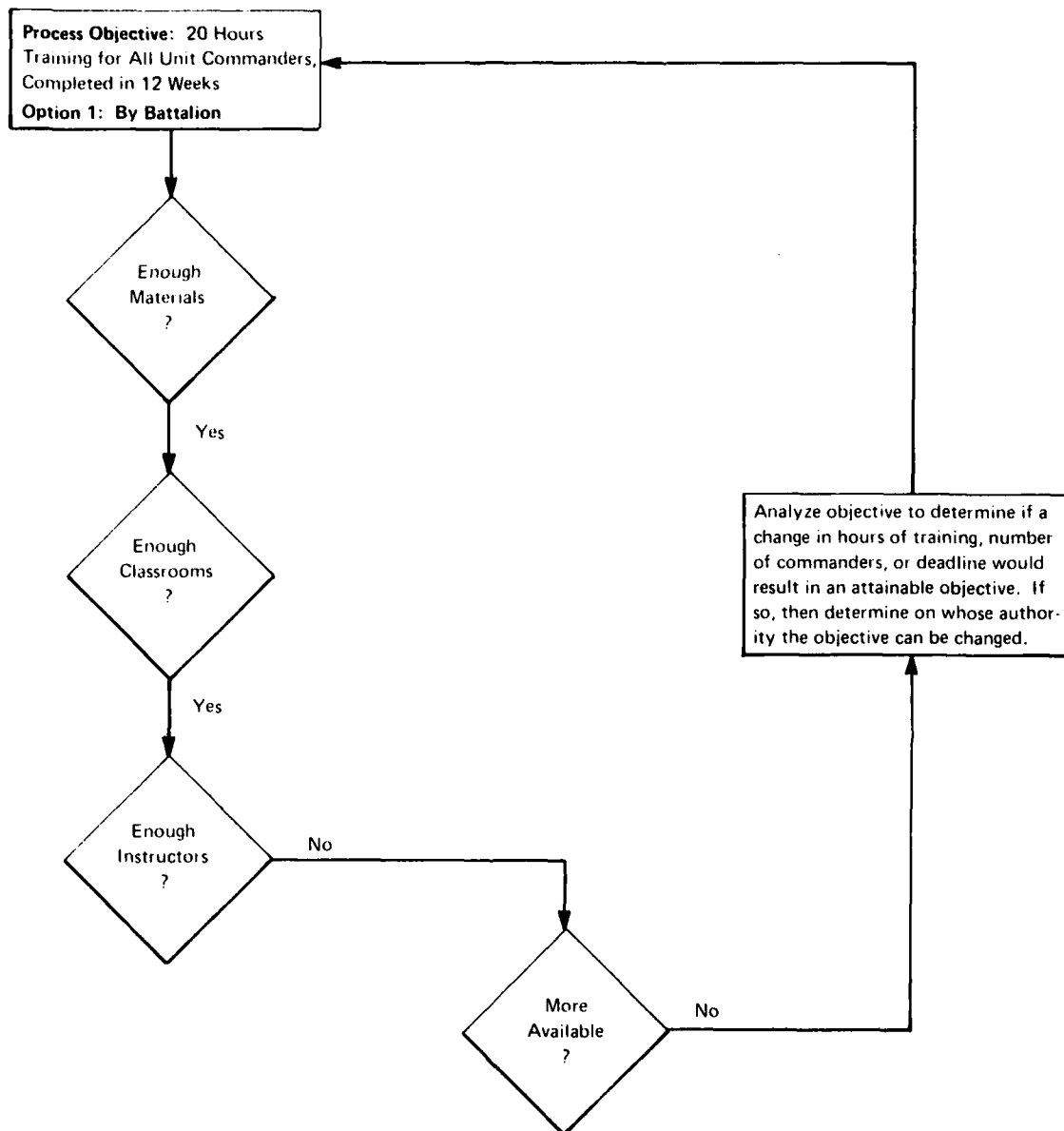


FIGURE 2 FEASIBILITY REVIEW OF A PROCESS OBJECTIVE

objective has an impact on the other parts, and compromise and adjustment are often needed before the objective can be finalized. By going through the procedure with care, program staff can make any necessary adjustments in process objectives with the assurance that they have first thoroughly considered all feasible alternatives and that the change will result in a strategy that can be implemented with available resources. If staff do not have the authority to change the objective on their own, they have accumulated all the data necessary to support a request either for a change in the objective or for additional resources.

3. Establishing Work Tasks

Once a feasible overall objective has been established, the details still need to be filled in. The process for establishing specific work tasks does not differ radically from the processes used in arriving at other military decisions:

- (1) Identifying options that can reasonably be expected to achieve desired results, taking into consideration the directives of higher authority as well as the experience of program staff and other programs,
- (2) Analyzing each option to identify its strengths and weaknesses,
- (3) Comparing options in terms of factors considered to be critical, such as cost, time to implement, or special staffing or materials requirements, and
- (4) Choosing an option on the basis of the relative criticality of the key differences among options.

(For example, the more expensive of two options might be chosen because the less costly one takes longer to accomplish, and it is critical to get the task done as quickly as possible.)

Table 1 shows a suggested format for simplifying the choice among options to achieve a given result; the table has been partly filled in for the purpose of illustration. The process of choosing strategies is discussed in more detail for each program component (education, other prevention, identification, and rehabilitation) after the discussion of program staffing and organization which follows.

B. STAFFING AND ORGANIZATION

Many personnel on the installation perform services for the ADAPCP or otherwise directly or indirectly influence its effectiveness. Section 1, below, deals with those personnel who are under the ADCO's direct control. Sections 2 and 3 deal with the interface of the ADAPCP with other personnel and agencies on the post.

1. The ADPCP Staff

a. Identifying Staffing Requirements

The process of staffing and organizing the ADAPCP begins with the identification of staffing requirements for each program component. The procedures recommended in this handbook should result in a broad indication of the staff positions to be filled--numbers of counselors,

TABLE 1

SETTING WORK TASKS

OBJECTIVE: All supervisors be able to recognize the smell of marijuana smoke.

<u>Options</u>	<u>Strengths</u>	<u>Weaknesses</u>	<u>Critical Factors</u>	<u>Decision</u>
A. Burn marijuana in class.	Authenticity Realism Confidence of students	Illegal Expensive Difficult to obtain	Requires approval of Dept. of Justice Expense	Not acceptable
B. Burn a facsimile in class	Legal Studies indicate smell cannot be distinguished from real thing		Inexpensive Easily obtained Within authority	Only available option. Choose it.

C.

instructors, clerks, etc. What is needed further is a detailed list of the functions of each staff member. A good place to start is the job description under which each existing position in the program was authorized and filled; however job descriptions are typically incomplete and are often outdated, and the list of functions should therefore include data obtained directly from people performing the functions and from their supervisors. If the program design calls for functions that are not currently being performed by anyone, these must be added.

The following is a sample list of functional components of an alcohol and drug counselor position:

- Individual counseling
- Group counseling
 - Family
 - Dependents
 - Soldiers
 - Spouses
- Coordinating medical support
- Planning and supervising recreation
- Advising commanders
- Briefing commanders and their staffs
- Instructing
- Receiving training
- Receiving supervision
- Filling out reports
- Doing other paper work

In developing such lists, it is better to err on the side of including too much detail rather than too little. Unnecessary data can be discarded later, and thoroughness at this stage can provide valuable insight into the functional components of staff positions.

b. Identifying Staff Resources

Once staffing requirements are identified, the next step is to identify existing staff resources. This is not as simple as it is in most military organizations. The reason is that some of the personnel authorized to be under the direct operational control of the ADCO are provided in manpower authorizations of the post's Health Services Command Medical Organization, and others are authorized in the manpower authorization documents of the headquarters and support staff of the post. Also, many installations have provided additional personnel resources to the ADAPCP from other agencies and organizations. Each of these sources of manpower authorizations should therefore be checked. As a final check to ensure that all position authorizations have been identified, it is advisable to try to match each person working in the program against one of the identified spaces. This may reveal that some other agency on the installation has, without any kind of formal agreement or authorization, provided an individual to work at one of the ADAPCP facilities.

These procedures should enable the ADCO to identify all of the personnel resources which are either formally or informally available for assignment to meet the identified staffing requirements.

c. Reviewing Staff Qualifications

Before personnel are hired or assigned to specific job positions within the ADAPCP, it is important to determine what qualifications will be expected of them. There are no universally accepted standards for the amount and type of training which qualify a person to work in alcohol and drug programs, and counselors and instructors from a wide variety of disciplines have been found to be effective in this field. Also, education programs and special training courses in substance abuse differ widely, and the title of a degree or name of a program may not indicate very much about the type of training received. For example, one person with a Master's degree in education may have taken all course work in the psychology and counseling department, and another with an identical degree may have taken all course work in educational methods and procedures. Obviously, they do not have the same qualifications. In assessing the qualifications of an applicant relative to program requirements, it is thus important to learn as much as possible about the content of that individual's training.

When the Army Drug and Alcohol Programs first started, there were very few people available with any experience or training in drug and alcohol rehabilitation or education. However, that is no longer the case. While a strong argument can be made that prior experience, training, or self-education are not absolutely essential for personnel entering the field, it is now realistic and feasible to set the standard that persons hired for ADAPCP positions other than clerical work must have demonstrated their interest in the field by becoming knowledgeable about the alcohol and drug problem.

Another qualification for personnel in the ADAPCP should be their willingness to accept the Army program and their roles in it. This should be checked out with all applicants before they are hired, and the staff training program should make clear the Army's goals and requirements. Some specific examples follow.

The Army's stated goal for the rehabilitation effort is to return the client to full duty or to discharge him. Many people in the counseling field are reluctant to accept responsibility for deciding that the rehabilitation effort for a specific client has failed and recommending that he be discharged. If a prospective counselor cannot accept that responsibility, he cannot function effectively in an Army program.

Another difficult area is the definition of substance abuse. The ADAPCP staff must accept the Army definition of abuse, regardless of their own opinions in the matter. The ADCO may interview a number of effective, dedicated, and in all other areas competent applicants for drug and alcohol counseling positions who cannot accept the Army definition of abuse. These personnel would be of limited value in the program.

Another problem area is that of mandatory referrals, that is, the participation in rehabilitation of personnel who are forced to participate by their commander. Many competent counselors are unwilling to accept other than voluntary clients. If a counselor will not accept involuntary clients, or if he agrees to accept them, but firmly believes that he is not capable of helping them, he will not be useful to the rehabilitation program.

Many professionals in the social sciences tend to view the function of a professional in the ADAPCP as one of changing the behavior of the

substance abuser. The interviewer makes sure that a prospective staff member is willing to focus on changing the client's behavior rather than that of the Army.

Another issue that needs to be discussed with each applicant to ascertain whether or not he can accept the Army program is confidentiality. Finally, every member of the ADAPCP staff must be able to relate to the command structure as well as to the client; since the effectiveness of the ADAPCP depends upon the support of the command structure at every level on the post, the program cannot afford to have a staff member who cannot maintain good relations with the command structure.

In general, these are the main issues which are peculiar to the Army program and which should be checked out with each prospective staff member. There may be other similar issues at a particular installation, and the ADCO should attempt to identify such issues.

d. Allocating Staff

Having identified staffing requirements for each program component, obtained an accurate inventory of staffing resources, and reviewed key staff qualifications, the ADCO can assign personnel to specific job positions. One process is to match the qualifications of available staff members with the requirements of each position. Here is where the detailed list of functional components of each position will become most useful. Table 2 shows a format which will simplify displaying the information needed to make staff assignments. It lists each position function across the top and each staff member down the side. The

TABLE 2
MATRIX OF STAFF MEMBERS AND POSITION FUNCTIONS

	Individual counseling	Group counseling	Family	Dependents	Soldiers	Spouses	Coordinating medical support	Planning and supervising recreation	Advising commanders	Briefing commanders and their staffs	Instructing	Receiving training	Receiving supervision	Filling out reports	Doing other paper work
William Smith	X		X				X	X	X	X		X	X	X	X
Marilyn Jones	X						X	X	X	X	X	X	X	X	X
Anne Brown	X		X				X	X	X	X		X	X	X	X
Charles Horne	X		X		X		X	X	X	X		X	X	X	X

capability of each staff member to perform each listed function is indicated by placing an X in the appropriate place on the chart, and the resulting matrix matches staff qualifications with job requirements.

In allocating staff, every effort should be made to assign each person to the position he desires if he is qualified for the job. If he is not qualified, the above procedure provides a useful tool for pointing out to that staff member the specific areas in which he needs improvement in order to wualify.

e. Adding New Staff

By this stage of the process, it will probably be apparent that the ADAPCP has more staff requirements than it has either present staff members or position authorizations. If so, there are several options. The first and most obvious is to identify each authorized position which is not filled and then contact the Civilian Personnel Office and request it to recruit for that position. Considerations to keep in mind when screening applicants have been discussed in Section c., above. If the authorized personnel are to be assigned to the ADCO by another agency, that agency should be contacted.

In filling job positions, first priority should probably be given to positions which provide direct rehabilitation to confirmed substance abusers. If there are clients in rehabilitation who fail because of the program's inability to provide proper rehabilitation efforts, this will have an adverse impact on every other component of the program.

If there are more requirements than authorizations, it is usually possible to supplement the staff with other personnel resources on the

installation, volunteers, and students. The procedures recommended above make it possible to identify and justify clearly and specifically each additional personnel resource required. The use of volunteers and students can be coordinated with the Army Community Services Center, which usually has a volunteer coordinator who will take on the task of recruiting volunteers. If there is a PhD psychologist on staff, he may be able to arrange for graduate students to do their practicums in the program. However, any use of non-paid labor in the program must be coordinated with the installation's Staff Judge Advocate to insure the limitations of government liability for accidents and any other potential claims resulting from work in the program.

f. Staff Monitoring and In-Service Training

The above procedures help to ensure as good a match between personnel and jobs as is possible in the program. However, continued monitoring of staffing requirements, resources, and qualifications is important as the program evolves. In addition, the ADAPCP should provide in-service training for its staff. Chances are that staff members represent a variety of previous training, education, and experience. The in-service training program can be used to bring all staff in comparable positions to a common minimum level of competence and a common understanding of program goals. It can also be used to broaden and deepen staff capabilities and to bring staff up to date on new findings regarding the alcohol and drug problem and new approaches to dealing with it.

The in-service training program can also provide opportunities for team building and a forum for dealing with problems experienced by the

staff. This is particularly valuable in the case of T/R staff. Counseling substance abusers can be an extremely frustrating task, and the resultant feelings of failure and inadequacy can impair staff morale and effectiveness if these reactions are not dealt with. It is therefore advisable to consider as a basic component of the in-service training program for T/R staff, and perhaps others, a regular weekly staff meeting at which problems and frustrations can be aired and discussed.

2. The ADDIC

Although Army policy makes it plain that the ADAPCP is a vital program and establishes enforceable mandates for compliance and participation, for practical purposes the best way to promote the program is to convince commanders and other leaders that program support is in their own and the Army's best interests. Therefore, one of the ADCO's major tasks is to gain support for the program. To do this, he needs to establish good relationships with the key personnel on the installation. The interviews and discussions with leaders recommended in Chapter III can be a useful step in this process. In addition, however, the ADCO should work with the Alcohol and Drug Dependency Intervention Council (ADDIC), which can be an ideal forum for communication between the program and the leadership structure.

The purposes of the ADDIC are to advise the CO on matters relating to the prevention and control of substance abuse and to act as a two-way communications link between the ADAPCP and other activities on the post. In addition, the ADDIC has the major unstated purpose of gaining general support for the program. In order to provide services that are needed,

the ADAPCP should have the advice and support of the key people representing the consumers of those services. If the program seeks their advice and does the things which they consider important, they will give it the support needed to accomplish its mission.

The ADCO does not have the authority to determine ADDIC membership, but he probably does have some responsibility for recommending who should be members. In making such recommendations, he should be careful to include people who are interested, either personally or because of their job positions, and people who influence decision-making in programs which either make use of ADAPCP services or affect the ADAPCP's ability to provide services. Obviously, the more influential the chairman is, the more effective the ADDIC will be. The ADCO should therefore generally attempt to get as high ranking an individual as possible to chair the ADDIC. (Desirable candidates are such people as the Assistant Division Commander--Support, Deputy Installation Commander, or Chief of Staff.)

An important consideration in making recommendations for ADDIC membership is the size of the ADDIC. It could include everyone who is an appropriate candidate, or it could be limited to the number of people the chairman feels comfortable working with on a committee. It may be desirable to have two classes of membership: members and observers. This makes it possible to limit the number of people actively participating in the meetings and voting on decisions, while maintaining a broad representation of the installation. The observers would be key installation personnel, who would observe all meetings and would address the ADDIC when requested. The ADCO's recommendations for ADDIC membership on a particular installation will depend on his assessment of that

installation's power structure, but the positions considered for membership should usually include the MEDDAC Commander, the Staff Judge Advocate, the Civilian Personnel Officer, the Adjutant General, the Director of Personnel/G-1, and a representation of commanders and key noncommissioned officers.

The ADCO is expected to function as the executive secretary of the ADDIC. This means that he performs homework and "leg work" for the chairman and provides the chairman with the information he needs to chair the meetings effectively. The ADCO typically assumes responsibility for recommending the agenda, notifying members, preparing minutes of meetings, and performing necessary follow-up to decisions made by the ADDIC. It is in his interests to ensure that participation in ADDIC meetings is meaningful, worthwhile, and beneficial to each member. A typical ADDIC agenda might include a presentation and review of certain program statistics to include data reported to higher headquarters, a presentation of problems for discussion and possible solutions, a brief educational experience for ADDIC members, and a discussion of problems confronting the consumers of ADAPCP services.

3. Role of MEDDAC Staff

The Army recognizes that the alcohol and drug problem has important medical aspects and expects that medical personnel will often function as specialists assisting the ADCO. Specifically, Army policy directs medical personnel to:

- Help to confirm whether a person is a problem drinker
or a drug user

- Manage acute intoxication from use of alcohol or drugs
- Manage withdrawal after substance abuse
- In some cases, assist in the rehabilitation process.

Unfortunately, cooperation between MEDDAC and the ADAPCP on many Army posts is less than optimal. This results from conflicts over authority and responsibility and failures of communication on both sides. The purpose of the following paragraphs is to discuss the reasons underlying the lack of full cooperation and suggest ways in which the ADCO might improve the situation.

The problem arises in part because of differing definitions of the nature of problem drinking and drug use. The MEDDAC staff tend to think of these as medical phenomena, to be treated using the methods and techniques familiar to medically trained people. On the other hand, the staff of the ADAPCP tend to look at the problem as a social one, to be dealt with by the tools available to the command chain.

The other--and allied--root of the problem lies in the division of responsibility for substance abuse control, which results in frequent differences of opinion concerning who is responsible for which aspects of the program. Although Army policy specifically assigns responsibility to the command component, the ADCO depends upon help from the medical component without having administrative control over it. Medical personnel retain responsibility for clinical evaluations of presumed problem drinkers and drug users and for providing facilities and services to accomplish detoxification and manage withdrawal symptoms. Personnel under the administrative control of the medical activity will in many cases function under the operational control of the ADCO as part of the

Alcohol and Drug Prevention and Control Team in the provision of rehabilitation services. Sometimes the clinical director of the rehabilitation component of ADAPCP is responsible to the medical activity for medical aspects of his activities and to the ADCO for command aspects. In all these instances, the medical personnel working in the ADAPCP continue to "belong" to MEDDAC. This means that the ADCO has little, if any, formal authority over them. He does not officially fill out or sign their personnel efficiency reports.

What can the ADCO do to obtain a good working relationship between the ADAPCP and MEDDAC? Success in accomplishing this would do much to strengthen the ADAPCP, and the subject therefore deserves treatment in this handbook. However, it should be noted that the suggestions made here are more subject to local variations than any other guidance offered in the handbook.

First, the ADCO would do well to talk with the CO and if possible also with members of the MEDDAC staff to learn the opinions and perceptions of medical personnel and communicate his own. Sometimes, a discussion like this can help set the stage for cooperation. At the very least, it will let the ADCO know what to expect.

Second, the ADCO should recognize the technical expertise of MEDDAC staff. They have been trained in various medical and therapeutic aspects of substance abuse prevention and control in a way that no one under the administrative control of the ADCO has been.

Third, the ADCO should be conscious of the other responsibilities of the MEDDAC. The fact that they have other commitments and responsibilities than the ADAPCP will have an effect on the resources they are willing to commit to that program.

Fourth, it would be well for the ADCO to familiarize himself with the history of relationships on his post between the MEDDAC and the ADAPCP. What has happened before cannot help but influence what happens in the future. At the very least, knowledge of the past can help the ADCO avoid repeating previous difficulties.

Fifth, there would be clear advantages both to the ADCO and to the MEDDAC staff in negotiating clear agreements about the exact responsibilities of MEDDAC in relation to the ADAPCP. Such agreements would indicate:

- Which MEDDAC staff will work on behalf of the ADAPCP
- How much time they will spend (weekly, daily, etc.)
- What their responsibilities will be
- What supervisory role the ADCO will have.

With regard to the last point, it might be possible to agree on a procedure whereby the ADCO submits recommended personnel efficiency ratings to the MEDDAC officer who will sign the forms.

Clear agreements will let all parties know what to expect. They will enable the ADCO to know to what extent he can depend on the MEDDAC to assist him in his program, and it will make clear to medical staff what their responsibilities and accountability are. In some cases, the process of negotiating such agreements may pinpoint areas of disagreement which the two parties are unable to resolve. Here, it is often wise to "agree to disagree." That is, the parties can recognize differences in points of view and leave them unresolved while referring them to higher authority for adjudication. However, it is important that in the interim, services be provided to clients who need them.

The parties can concur that the nature of the interim services provided will not prejudice the decision to emerge from the adjudication process.

C. EDUCATION

Some of the major factors to be considered in designing and organizing programs of alcohol and drug education are discussed below. Footnote numbers refer to the list of references in Section 11.

1. Background

The research conducted on drug and alcohol education programs has produced almost no empirical evidence about whether any of the various types of programs tried thus far are effective.¹ Indeed, there has been considerable controversy over these programs. They have been criticized for a variety of reasons:² the program goals have not been clearly thought out and stated; the educational methods employed have not been carefully chosen; and there has been very little planning for the provision of evaluation of program effectiveness.³ There appears to be a general consensus that a good deal of the money thus far expended on drug and alcohol failed. Several people⁴ have suggested that the reason for this failure is that the programs have concentrated on drugs or alcohol per se as the problem, rather than probing further and dealing with the psychological or societal causes of which substance abuse is a symptom. In this view, drug use and problem drinking are attempts by individuals to cope with or to avoid stresses due to other problems.⁵

Governmental agencies, social service groups and individuals have changed their philosophy regarding substance abuse in recent years.

They are no longer treating the abusers as criminals, but are beginning to look on them as human beings with problems. This can be expected to result in new approaches to alcohol and drug education.

Traditional programs of alcohol and drug education were typically designed to provide information about these substances.⁶ They usually presented the same contents to all the students in a school or soldiers on a post.⁷ Drugs and their uses were enumerated, with their potential side effects and the legal consequences of their use. The material was generally presented by an authority figure (teacher, principal, police officer, minister, military officer), who tried to frighten the audience by emphasizing the physiological and psychological dangers of substance abuse and the punishments that could ensue, and who associated substance abuse with a lifestyle that was ugly, unhealthy, and corrupt.

The students or soldiers receiving this instruction generally varied widely in prior knowledge of, and experience with drugs and alcohol. As a result, on the one hand, individuals who might have had little or no interest in drugs and alcohol were introduced to a great deal of possibly tempting information on drugs and their uses,⁸ while, on the other hand, the credibility of the programs was impaired as experienced substance abusers noted exaggerations or other inaccuracies in the course content and pointed these out to their less knowledgeable friends.⁹

These problems have also been manifested in audiovisual and other media about alcohol and drugs. Informational brochures and film strips have often presented more detailed information about drugs than either users or non-users would otherwise be likely to obtain. Hundreds of

drug education films have been produced in the past few years, but a recent three-year evaluation (reported in 1972) concluded that 84% of the most commonly used drug education movies were "scientifically and conceptually unacceptable." Of the more than 200 films that were screened, only 34 were approved.¹⁰

2. Factors to Consider in Program Design

A review of the research to date suggests that there are several factors that ought to be considered by an Army post planning the content and structure of its drug and alcohol education program. As noted above, the "information-oriented" approach risks encouraging experimentation with drugs and alcohol. If the program tries to offset this by overstating the dangers involved, it risks loss of credibility. Thus, while alcohol and drug information is useful for some purposes, it should not be expected to cause a reduction in substance abuse or to implant negative attitudes toward drugs and alcohol.¹¹

It would appear that one's self-image, one's attitudes and values, and one's friends are the most common determinants of behavior change. It thus seems possible that a program which successfully changed attitudes could result in a drop in the number of substance abuse incidents. Appendix F discusses the problem of changing attitudes.

As a form of communication, education can be described in terms of the six components of the communication process:

- (1) The source or the communicator (who says it): Certain factors affect how much influence this person has on the audience.

- (2) The message (what is said): Messages may be varied for different kinds of effectiveness.
- (3) The medium or channel (how the message is sent): The mode or the vehicle for a message may have as much influence as the message itself.
- (4) The environment (where and with what kinds of emotional overtones the message is delivered): The physical surroundings in which the communication takes place, as well as the manner in which it is delivered have a definite effect on the communication process.
- (5) The receiver (the person who sees or hears the message): The person receiving the message is certainly not passive, and his way of relating to the world may be the single most influential factor in shaping his reaction to the communication.
- (6) The destination (are there short-term and/or long-term effects? Do changes occur in both opinions and actions?) Unless there are sustained attitudinal changes and the person is in effect "immunized" and develops a resistance to taking drugs or alcohol, the communication process and the program cannot really be considered successful.

3. The Communicator

Studies suggest that three factors are most important in determining the effectiveness of the communicator.¹² These are credibility, attractiveness, and power.¹³

One would assume that a person who appears to be knowledgeable about a subject will have more influence in communicating than one who is perceived to be ignorant. Attitude change studies¹⁴ have found that short-term attitude change is greatly increased if when a persuasive message is associated with an expert in the field. Over time, however, the differential of high vs. low credibility communicators tends to wash out, and the message becomes dissociated from the source.

The second factor is attractiveness. People are much more likely to be attracted to others whom they perceive to be similar to them in outlook, orientation, values, goals, and so on. Attractive sources are more influential than unattractive ones. If the receiver determines that the person sending the message is similar to him, then he is likely to accept and adopt the message. If the receiver later finds that the source is not like him, he may reject the message as well.

The third factor is power. In some cases the communicator has the power to force compliance with his message. Peer group pressure is often an example of this type of power. However, resulting changes in behavior are often temporary. When the group's norms are changed or when the concern for conformity is removed, the person is likely to revert to his former attitudes and behavior.

Several implications come to mind concerning the structuring of a drug and alcohol education program. If soldiers are most likely to be influenced by persons similar to them in outlook, values and goals, then it would seem desirable to use a soldier as the communicator.¹⁵ If possible, it would be helpful to get someone who is a peer group leader. Such an individual might play an important role in swaying the

group's norms or in showing that the need for conformity to norms of using drugs or drinking heavily is no longer there--at least for one person. This may then enable some people to return to their former behavior as non-abusers of drugs or alcohol.

4. The Message

The message being communicated should generally be rational rather than emotional and explicit rather than implicit. It should be presented clearly and in a style appropriate to its audience, and the ordering of materials should be carefully considered.

Communications may be rational or emotional in their presentation and in their appeal. Often, messages are designed to arouse anger or fear in the receiver. Scare tactics, showing "what drugs did to people just like you," and "bandwagon" appeals may be used to show people why they should change their minds and their behavior. However, studies have shown that increasing the amount of fear aroused in a communication decreases the acceptance of the message.¹⁶ People who are frightened by the contents of the message may become defensive and skeptical or may repress the implications of the message, and sophisticated members of the audience are likely to be scornful of the approach. In general, then, it is probably best to have drug and alcohol education programs grounded in the rational rather than the emotional.

The message may be explicit or implicit. Most messages are found to be more effective if the conclusions are explicitly drawn, rather than implied with the receiver left to draw the conclusions for himself. A related issue is whether to present the arguments on both sides.

Research studies¹⁷ have indicated that people who were convinced of a position after exposure to both sides of the argument were strikingly more resistant to later communications which attempted to reverse the position. In one study of military men,¹⁸ where the men were split into two groups, depending on whether they had low or high educational backgrounds, the low education group was generally more persuaded by one-sided arguments and the high education group was more persuaded by two-sided arguments. This would suggest that different messages need to be presented to different groups of people.

The style and clarity of presentation are also important. But there is little agreement about whether dynamic or subdued presentations are more effective or whether humor or seriousness is preferable. The speaker's delivery effectiveness does appear to have some relationship to the attitude-change impact of the message. Well-organized messages are easier to comprehend than poorly organized ones; hence one might expect that they would have more impact on rational attitude change. However, well-organized, dynamic, intense presentations are sometimes perceived as propagandistic and this may lead receivers to discount them somewhat. Again, the choice of style should depend on the type of audience, particularly its sophistication and education level.¹⁹

The order in which materials are presented is important. Apparently it is better to have agreeable materials (the good news) first and disagreeable materials (the bad news) second. The presentation should be organized so that a summary of conclusions is presented first; this enables the receiver to have a roadmap, to know where the presentation is going. This often has the additional effect of piquing and sustaining

interest as the receiver watches for shifts in topics or for the conclusions that have been summarized to be supported. One recalls the old saying: "Tell them what you're going to say, say it, and then tell them what you said." Learning theory indicates that the material that appears at the beginning of a presentation is best learned and what appears near the end is second best learned, while the material in the middle may not be learned at all.²⁰

All this has some implications for Army programs of alcohol and drug education. Messages should be designed with a target group in mind, and it is wise to know as much as possible about the audience (age, sex, socioeconomic status and educational background). For those with lower education backgrounds, rational but one-sided presentations will probably be more effective than the two-sided, logical debates that those of higher educational backgrounds will need in order to be convinced. Presentations should be well-organized with conclusions stated first and last and the supporting arguments and development of those conclusions comprising the middle section of the presentation. Appeals to emotion and attempts to arouse fear or anger should rarely be made.

5. The Medium or Channel

The medium through which the message is communicated needs careful thought when one is contemplating a presentation.²¹ There are several characteristics on which different media can be ranked:²²

- Prestige: Some media have greater prestige value than others, and a person may more readily accept the content if it is "packaged" in a high-value medium.

- Credibility: Like the communicator, the medium should be credible. People may be more willing to believe the communications that appear in certain magazines because they trust the editorial policy of that magazine; the same is true for news that is produced by one television station over another.
- Capacity to attract and hold attention: Radio and television have the ability to attract large audiences, but they are easier to shut off than a face-to-face conversation.
- Extent of audience participation: One problem with radio, television, and film-strips is that they do not allow the audience to become actively involved; the audience is passive for most of the time. Printed materials engage the reader to some extent, but lectures and discussions are far preferable.
- Visualization: For some types of issues, a message is much more effective if accompanied by visual presentation. Television and face-to-face interaction both allow this to occur.

It would appear that one of the best media through which soldiers might be taught is small-group discussions;²³ a second might be television. In both instances the audience can see and hear others like themselves discuss the issues. Face-to-face discussions have the advantage of involving the soldiers in active participation. Research

studies suggest that a person who commits himself to his opinions publicly is less likely to change them than one who remains passive and unengaged. Two-way communication also enables the communicator to get immediate feedback as to whether the message is getting through to the receiver and, if not, to change his presentation or medium to achieve his end. We would suggest that use of different media, depending upon the message, might make the presentations more varied, hence more interesting, but not necessarily more effective.

Of course, practical considerations may intervene here. Small-group discussion may be the medium of preference, but education in small groups is expensive in terms of time, facilities, and number of instructors. The decision made on a group size will have to strike a reasonable balance between minimum cost and maximum effectiveness.

Although different objectives may have been chosen for different target audiences, it does not necessarily follow that the audiences must always be separated. For example, if one program goal is that all officers and senior NCOs should be more understanding toward drug usage on the part of junior enlisted men, this might best be accomplished by confronting the issues in small groups of all ranks, while it would be very difficult to accomplish in segregated lectures. However, it would probably be useful to give the officers and senior NCOs some basic drug information prior to this. Thus, the program will probably have a variety of audience "mixes."

6. The Environment

The effectiveness of a communication may be influenced by the context or situation in which it takes place.²⁴ Several research studies have suggested that the more agreement one perceives among his associates concerning an issue, the more likely he is to join in this agreement. Presumably people conform to group norms in order to secure the approval of others in the group. Conformity also assures one of positive feedback from others, and this makes one even less likely to change one's position or attitude. Researchers have also demonstrated that the presence of one non-conformer has dramatic effects in freeing the individual to respond as his senses dictate. There is little doubt that the social support system that one lives in has a definite relationship to one's attitudes.

Likewise, whether or not a person feels alienated will affect how he receives messages. In an environment where there is a high degree of centralized power, where impersonal relationships are predominant, and where the demand for conformity is high, feelings of alienation result, and one is drawn even more to depend on peers; this intensifies the need for social acceptance in the group and in turn increases the amount of conformity.

Since the military service demands conformity and is organized around centralized power and impersonal relationships, the environment has some built-in impediments to attitude changes. There should be a recognition and acceptance of the importance of peer group norms and social acceptance. If substance abuse is an accepted norm among soldiers, then new soldiers coming to the post--even those who have never been

abusers before--are going to be under pressure to try drugs and alcohol in order to be accepted by the group. The ADAPCP can try several strategies. One might be to try to find one nonconformist who does not go along with the group norms and help him form another informal group with its own norms of non-abuse. Another possibility is to try to substitute alternative norms for the group, hence moving the whole group's norms to another style of behavior. In addition, the environment in which the drug and alcohol education program is delivered should be as free from any feelings of centralized authority, required conformity, and impersonal relationships as possible. It is important to relieve the feeling of alienation if it exists, as this will probably inhibit attitude change.

7. The Receiver

Thus far, the discussion of education strategies has focused mainly on external factors concerning the communication. Little has been said about the recipient himself, although the fact has been noted that some messages affect receivers differently. It has also been suggested that the status of a person is related to his conformity; those in low status will conform more to persons in higher status than vice versa. But it has also been found that people react most favorably and are most likely to change their attitudes when someone who shares their values and so on is proposing an alternative,²⁵ as opposed to an "expert" with whom the receiver cannot readily identify as being like himself or herself.

A variety of studies suggest that persons high in self-esteem are more resistant to influence attempts than those low in self-esteem.

This would mean that those who have high self-esteem and are not substance abusers are not likely to become so; however, if they are abusers, it will be very difficult to change their attitudes. If their self-esteem can be raised through social feedback, however, they might reach a point where they felt free to discard substance abuse.

8. The Destination

It appears that communication from a high-credibility source to a person with low esteem and low education background may have considerable effect. But will it cause only a short-term change in behavior,²⁶ and what about the person's ability to withstand subsequent influence attempts made by others? Several factors appear to be helpful in maintaining the stability of a person's new behavior and his resistance to counterchange.

- Public Identification: As previously indicated, publicly committing oneself to a stand on an issue causes one to be more resistant to subsequent counterchange. Once a person has identified himself with an attitude or value, he risks great social pressures if he later changes his mind.
- Linkage to values and beliefs: If a person's position is linked to other values and beliefs, he is less likely to change his position.
- "Inoculation theory": In a series of well-controlled studies, a prominent researcher found that when a person has simply received support for his beliefs, he is more

vulnerable to changing back than if he has had to cope with a refutation. In addition, a forewarning of an attack on one's beliefs has the effect of immunizing against change.

- Individual differences: Two personality characteristics have been identified which are particularly important to attitude change. These are dogmatism and emotional dependency on the status quo. The more dogmatic and emotionally dependent one is on maintaining things as they are, the less likely one is to change attitudes or behavior. However, if one does undergo a change, one is even less likely to revert to the former attitude or behavior.

9. Organization

The way in which the ADAPCP is to accomplish its educational objectives is a basic consideration that will impact on all others. One issue is centralization versus decentralization. If all education is to be conducted by a group of instructors under the ADCO's direct control, either a large organization of instructors will need to be established, or the program will take a long time to complete. If responsibility for providing instructors is instead left to each unit, these problems are avoided, and there is the additional benefit of encouraging greater unit-level involvement in the program, but some of the ADCO's control over the program is sacrificed and the task of program monitoring complicated. Thus, each approach has its advantages and disadvantages.

At one time, alcohol and drug education was considered to be such a highly specialized field that a totally centralized program was the only option. However, current wisdom indicates that it is possible for program staff to train additional instructors and that a decentralized approach to training may be less expensive and for most purposes more effective. One possibility is to establish a small team of highly trained instructors to train unit representatives and provide them with backup services (assistance visits, media library, etc.). This same group could then be used to teach certain specialized courses to other special groups (chaplains, social workers, commanders, etc.). If this group establishes a continuing relationship with the trainees, problems of program control and evaluation can probably be minimized.

10. Summary

It appears, then, that alcohol and drug education programs need to be differentiated according to the age, educational background, and so forth of the soldiers at the post, and that neither simply presenting information nor attempting to frighten the audience is likely to bring about much reduction in substance abuse. While several approaches may be used for variety's sake, the most effective approach is probably group discussion, providing two-way communication among people of similar backgrounds and values. While a centralized program simplifies program monitoring and control, some degree of decentralization may be preferable for reasons of cost and increased unit involvement.

Finally, as the previous chapter has suggested, the causes of substance abuse on the part must be studied. Alienation, lack of social interaction, low morale, lack of alternatives to substance abuse such as other social activities, and group norms and standards of conformity all may contribute to the problem, and to the extent that these causes are identified, it may be possible to make constructive changes to address them. Some of these changes may be independent of the education program, and these are discussed in Section D of this chapter.

11. References

The various research findings about alcohol and drug education mentioned above are described in the following sources. Numbers correspond to the footnote citations in the text.

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D. OTHER PREVENTION: COMMUNITY ACTION/ENVIRONMENTAL IMPROVEMENT

Education is only one element in substance abuse prevention, which includes all activities aimed at preventing people from starting to use drugs or drink to excess and inducing them to stop if they have already started but have not been confirmed. The other principal contributors to prevention are law enforcement and community action, the latter largely aimed at improving the military environment. Law enforcement will not be discussed here since the ADCO cannot assign duties to law enforcement personnel (though, as discussed in the next chapter, it is important that he understand thoroughly those law enforcement activities which interface directly with his program). The ADCO, of course, does not control the environment either, but he and his staff may be able to exert some influence on it by enlisting the cooperation of individuals and agencies on the post and mobilizing energy around goals relevant to the prevention effort.

Drugs and alcohol are used within the context of the military environment and in turn have an effect on that environment. It is known

that substance abuse occurs on as well as off duty, and DA policy specifies certain community action objectives for the drug program which include both on-duty and off-duty aspects of the military environment. The degree and nature of ADAPCP involvement in identifying and choosing tasks for environmental improvement will depend on the amount of responsibility and authority assigned to the ADCO by the CO and on the channels of communication open to him. In many cases it may be best to work through the ADDIC.

1. Boredom in the Army

One factor that sometimes contributes to drug use and excess drinking, or at least impedes efforts to reduce them, is boredom. If boredom is widespread at a particular installation, the ADAPCP might explore whether this is a determinant of substance abuse and, if so, what might be done about it.

Boredom implies the unavailability of activities which are satisfying or interesting to an individual. Since individuals vary, it is unrealistic to expect to create a situation in which no one will be bored; however, if life satisfiers are lacking for a large proportion of people on the post, it may be possible to identify changes that would be helpful to many.

The best way for the leadership structure to begin dealing with this problem is probably to establish communications with enlisted men that are as open and candid as possible. This will help the unit commander and other members of the LS to find out the problems of enlisted men and what changes would increase their life satisfaction. The LS is then in a position to make those changes which are feasible and consistent with mission accomplishment.

2. The Off-Duty Environment

One way to help prevent boredom from becoming a problem in the off-duty environment is to make sure that recreational facilities and services are adequate. The consideration here is often not so much one of introducing new facilities as one of making sure existing facilities are fully usable. The large modern bowling alley on the installation may appear to be adequate, but if the troops do not use it because they have to wait too long for an alley, or there is not a sufficient variety of shoe sizes, or neckties are required, or the facility is too far from the troop billet area, or they do not know how to bowl and there is no provision for teaching them, then this particular facility does not provide satisfaction to them. The troops themselves are the best source of information on such inadequacies, as well as on what new facilities or services are needed, which existing ones are the most popular with all troops, and which are most popular with substance abusers.

Since recreation is not the ADCO's responsibility, he will have to move more cautiously in this area, particularly where the adequacy of existing facilities and services is concerned. Recreation service personnel will be glad to receive ADAPCP support in documenting the need for something new, but they may resent the suggestion that what is available is poorly managed.

In addition to recreational facilities and services, other aspects of the off-duty environment may be of concern to the prevention effort. For example, the amount of time designated as "off duty" may be inadequate or may be inappropriately grouped. This bears particular scrutiny with

units that are frequently on some sort of alert status and with individuals who work on a shift schedule. For example, at one extreme a 42-hour week could be scheduled by having the men work six hours every day of the week. In this way no one would ever work more than six consecutive hours and no one would ever have more than eighteen consecutive hours off. At the other extreme, a supervisor might think that he is doing his subordinates a favor by allowing them to work three days per week, 14 hours a day, thereby doing their 42 hours and still getting four days off. In reality the supervisor might be encouraging the men to use amphetamines to stay awake on the job and barbiturates to get to sleep rapidly when they get home.

3. The On-Duty Environment

This, of course, is in the hands of commanders and first line supervisors. One area of concern can be readily seen if it is understood that so long as soldiers have challenging work to do it is impossible for them to use drugs to any significant extent while on duty without being detected. The reason is that drug use will interfere with their ability to consistently accomplish challenging tasks. Also, if soldiers are assigned to jobs that are consistent with their qualifications and training, they are less likely to be interested in drugs. Soldiers who are dissatisfied because their work bores them may use drugs to cope with the boredom. Thus, one way to help prevent substance abuse is for Commanders and first-line supervisors to challenge their troops and to assign them jobs for which they are qualified and trained. ADAPCP staff obviously cannot enforce this, but they can point out its desirability.

Another on-duty factor which influences drug abuse, but which commanders may be reluctant to acknowledge is that of personnel accountability. The expectation that all supervisors know where their subordinates are and what they are doing during duty hours tends to go unquestioned. In reality, however, it is very difficult for this supervisor to keep track of everyone. At any given moment there are many soldiers on the installation who have time off because of previous overtime for guard duty, field exercises, and a multitude of other activities, all serving to make it virtually impossible for the supervisor to be sure of the whereabouts of every man. The fact that there are always people walking around unaccounted for during duty hours enables many troops who are in fact on duty to escape close supervision and thereby to use drugs while on duty without getting caught; in fact, the challenge of evading detection can be a motivation for using drugs on duty. While the difficulty of controlling this is real, the ADCO can make a strong argument for efforts to tighten up accountability by pointing out that the situation as it is encourages drug use, enables people to avoid doing the work they are paid for, and in general impairs efficiency on the post.

Another aspect of the on-duty environment which can be influenced by commanders and supervisors is the fact that there is often no reward for a better than average performance. For example, many training regulations require soldiers to attend training on a routine periodic basis whether or not they already know the material or have mastered the skill. A soldier has no incentive to learn the material if he will have to repeat the training anyway, and if he does learn it he will be bored by its repetition. The incentive instead is to "tune out," pay no

attention, and use drugs if they are an available distraction. The drug user will not be detected if the whole class is as inattentive as he is. The ADCO again cannot do anything about this directly, but he can discuss with the LS the value of rewarding good performance and the possible relationship between lack of rewards and substance abuse.

4. The Influence of Helping Agencies

Adequate helping agencies should be available to prevent substance abuse from developing as a result of personal problems which are not being remedied. During the process of assessing the problem on the installation for example, ADAPCP staff may have determined that the target population includes a high percentage of married soldiers who are separated from their families. It might be important then to check the adequacy of agencies which are designed to help soldiers and their families in this situation.

E. IDENTIFICATION

The identification of people who need detoxification and/or rehabilitation services is very difficult because of the legal problems and the problems of denial. Because most drug use is illegal, drug users are obviously often reluctant to voluntarily seek help from official agencies, and the people closest to them are reluctant to turn them in. Many users are reluctant to volunteer under the exemption policy for fear of unofficial retribution or other perceived disadvantages of being known as a confirmed drug user: harrassment, loss of security clearances, reassignment to less sensitive (and less attractive) occupations, and lowered

performance ratings. In addition, substance abuse is typically characterized by complex alibi systems and rationalizations designed to deny that it is a problem.

Therefore, in addition to the means already available for implementing the exemption policy, methods are needed to help the command and others (peers, chaplains, etc.) identify substance abusers who do not volunteer and get them into rehabilitation programs.¹

In addition, unless the installation is isolated from the civilian community, systems are needed for referrals from local civilian service agencies to the ADAPCP. Many of these methods are prescribed by higher authority, but the ADCO and his staff have some options for implementing them.

1. Administrative Quality

One of the most critical factors influencing the identification program is the administrative excellence with which the referred individual is handled. Many purely administrative factors, completely unrelated to the effectiveness of evaluation, treatment, or rehabilitation, may encourage or discourage referrals into the system. It must be recognized that identification through other than voluntary means is almost completely in the hands of personnel not reporting to the ADCO. After they recognize that an individual is a problem drinker or drug user they must be willing to take the appropriate action to enter him into the system. Key people on the installation will be reluctant to refer individuals to the ADAPCP if they have previously had unsatisfactory experiences in doing so.

1. This handbook does not deal with the subject of clinical confirmation, since the ADAPCP does not have direct control over this process.

To take some examples, if a chaplain encourages and influences a soldier to turn himself in for rehabilitation, and this becomes common knowledge in the soldier's unit because of sloppy confidentiality procedures on the part of the ADAPCP or of the soldier's unit, that chaplain may hesitate to make another referral to the program. If a commander sends a man to the program for evaluation of suspected drug use, and the man sits in the waiting room for four hours waiting to be seen, that commander also may be reluctant to make additional referrals. If a military judge or commanding officer suspends a soldier's sentence on the condition that he participate in the rehabilitation program, and then subsequently discovers that because of unsatisfactory administrative procedures a complete medical/social evaluation was never completed on the man and he therefore never entered rehabilitation, that judge or commander will also be reluctant to refer people to the program.

Unfortunately for the APAPCP, each of these key people will also have a major influence on the attitudes of his associates concerning the program. These examples should make it clear that administrative systems which link the initial identification of a substance abuser with eventual entry into the rehabilitation program must be closed systems which allow for no mishandling of either people or paperwork.

2. Charting the Identification System

It is desirable to make explicit the administrative processing system for each source of referral on the post. According to DA policy, every one on the post is potentially a referral source, since everyone is expected to be alert to indications that someone is having alcohol or drug related problems.

Flow charts provide a useful way of describing the identification process. The first step in charting the process is to identify its input and the output. The input is any individual or organization that notices that a person is exhibiting behavior which may be caused by substance abuse, and the output is the outcome of the procedures which evaluate the suspected abuser. Figure 3 is a sample flow chart of an identification system. Listed in the left-hand column are the sources of identification. On the right are listed the three possible outcomes of the process: (1) no steps taken with respect to the suspected substance abuser if the medical/social evaluation fails to confirm the abuse, (2) entry into the rehabilitation program (either because of information as an abuser or for other problems), and (3) appropriate discipline. Two procedures, one or both of which are required for every suspected substance abuser, are listed in the center of the chart under the heading, "process." Arrows are used to show the flow of the suspected substance abuser through the system.

As a next step, a separate flow chart can be constructed for each "identifier" listed on the first chart, describing step-by-step the procedures involved in moving the suspected substance abuser from that identifier to each possible outcome. The chart would be accompanied by a detailed description of the reports, coordination, and other feedback requirements at each stage in the process. If each potential "identifier" has a copy of his own chart, he can tell at a glance exactly what his options are for dealing with the suspected abuser and what procedures he should follow to implement each option.

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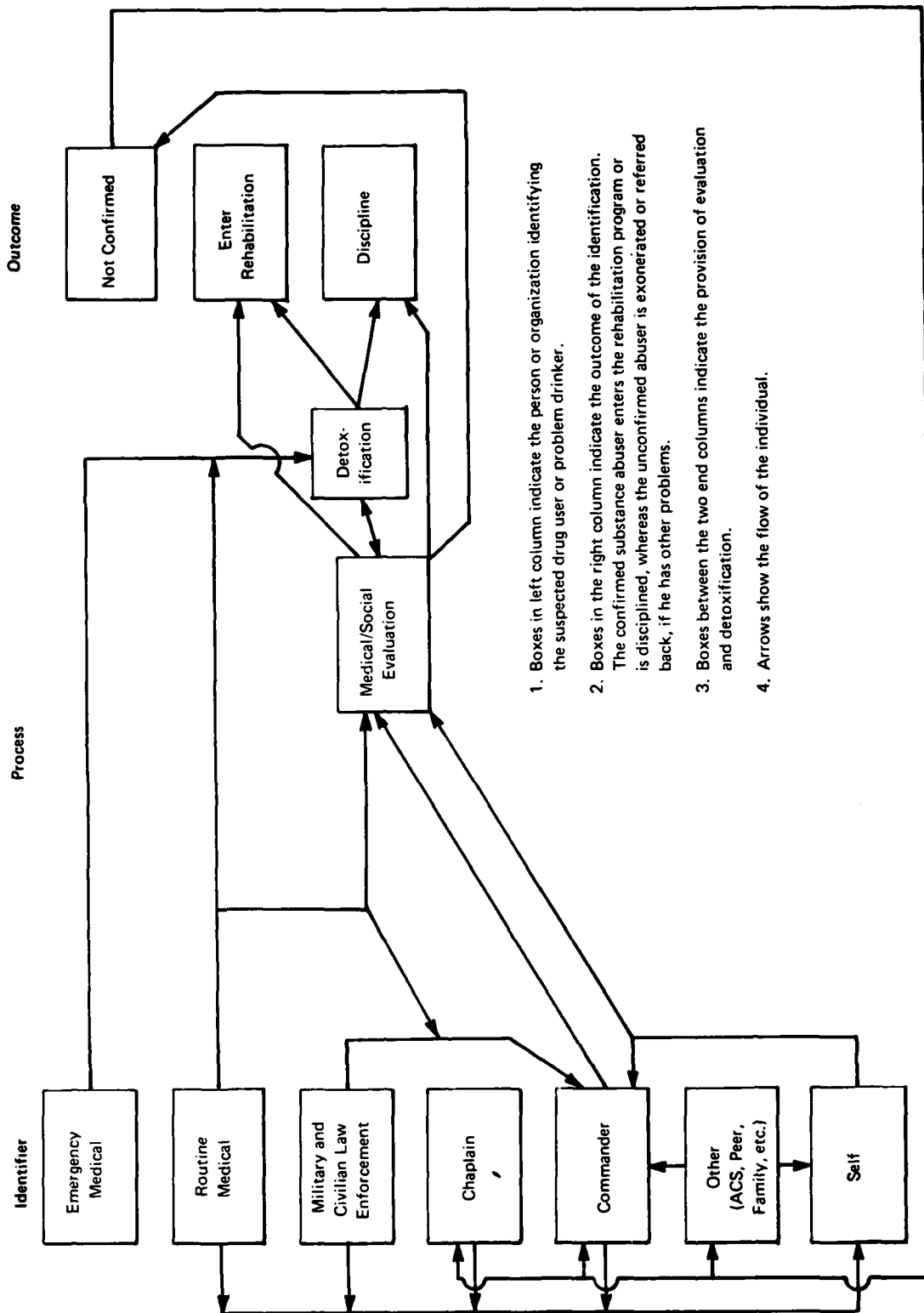
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1. Boxes in left column indicate the person or organization identifying the suspected drug user or problem drinker.
2. Boxes in the right column indicate the outcome of the identification. The confirmed substance abuser enters the rehabilitation program or is disciplined, whereas the unconfirmed abuser is exonerated or referred back, if he has other problems.
3. Boxes between the two end columns indicate the provision of evaluation and detoxification.
4. Arrows show the flow of the individual.

FIGURE 3 FLOW CHART OF AN IDENTIFICATION SYSTEM FOR SUSPECTED PROBLEM DRINKERS OR DRUG USERS

3. Setting Priorities Among Referral Sources

If referral systems do not appear to be working as they should, it is worthwhile devoting considerable staff energy to their improvement. In view of the large number of sources of entry into the program, it may be useful first to prioritize them.

The first step is to list all the program's sources of referral, grouped in some logical manner; for example, the following:

- (1) Those sources which are daily in direct contact with the drug user/problem drinker (his commander and supervisor, his associates/peers on and off the job, his family, and himself).
- (2) Those sources which are the result of an emergency or crisis to him (emergency medical facilities and law enforcement).
- (3) Those sources to whom he may turn for help with a drug or other problem (chaplain, Army Community Services, American Red Cross, Mental Hygiene Clinic, etc.)

The list can then be reviewed to see which sources or categories account for the most referrals (either actually or potentially) and which are not referring as many people as it appears they should be. These two groups should probably have highest priority.

To encourage the high-priority sources to refer suspected or known substance abusers to the ADAPCP, it is probably necessary to go out and "sell" the program to them very actively. This means talking to them on a regular basis, making sure they know what the program can do for the individuals referred, answering their questions, and responding to whatever criticisms they may have of the administrative and other functioning of the program (and possibly members of its staff).

F. REHABILITATION

This section looks at the process of choosing strategies for rehabilitation. First, it discusses the state of the art of rehabilitation and the lack of simple guidelines for the selection of treatment modalities. Next it shows how an objectives-oriented flow chart can help program staff to identify key decision points and establish intermediate objectives between the rehabilitation input and output. It goes on to explore options concerning the halfway house, the involvement of significant others in the rehabilitation process, and the possibility of obtaining additional modalities for the program.

1. The State of the Art

The current state of the art provides no clear guidance in choosing the appropriate rehabilitation modality for a given type of client. Practitioners cannot agree, and empirical evidence is inconclusive. This places a major burden on counselors to assess each client individually and design a program to meet the objectives of restoring him to a full-duty status, free of alcohol or drug problems, or else determining that he should be discharged.

The need for improved knowledge in this area might be an incentive for ADAPCP staff to compare and contrast the effectiveness of two or more rehabilitation modalities at the installation. (The next two chapters treat this subject further.) Meanwhile, the best the ADCO can do is to make sure that each member of the rehabilitation staff knows and can use competently at least one modality or technique. The Clinical Director of the rehabilitation activity, who is responsible for the technical medical

aspects of the program, can be of assistance in this respect.

2. Flow Charting the Rehabilitation Process

Flow charting the rehabilitation process can be a help in organizing the task of program design. One possible chart of the process is shown in Figure 4. Again, a good approach to preparing such a chart is to list the input and the output and then fill in the intermediate points. Note that this flow chart is related to the basic goal of rehabilitation established by DA policy, to restore soldiers to full-duty status or to provide continuity of treatment for separatees.

Since the DA goal focuses the rehabilitation effort on the man's duty status, it is helpful to identify the various phases of the rehabilitation program in relation to duty status. The flow chart is therefore designed to trace the flow of a client from entry into the program through various categories of duty status (from no duty to part duty, to full duty with increasingly limited involvement with the program, to full duty without any involvement with the program), while also showing the process by which a rehabilitative failure is eventually discharged from the Army.

The flow chart shows clearly when and where key decisions have to be made during the rehabilitation process. For example, it is obvious that a decision must be made each time a client progresses from one duty status to the next. This points to the need to establish decision criteria. In the course of doing this, program staff will probably find that there is a tendency to think in terms of process-oriented rather than results-oriented criteria for these decisions. For example, the current tendency is to state that the client will progress from full-time residency in the

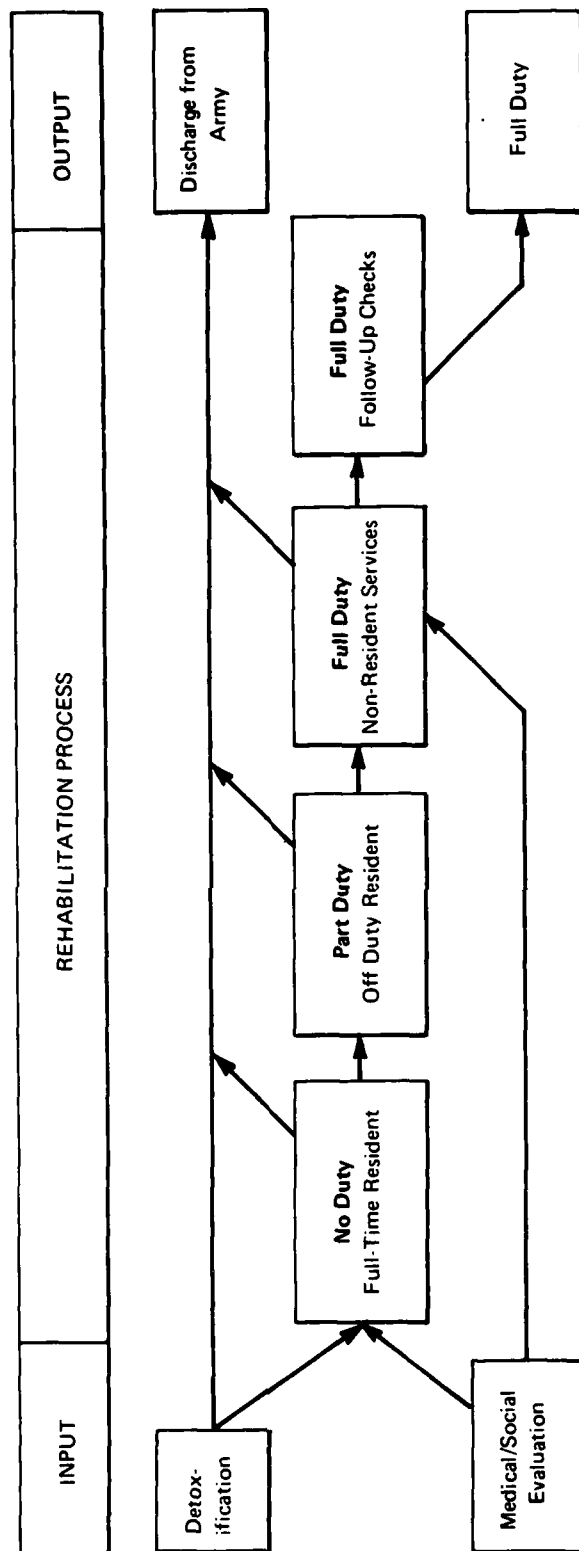


FIGURE 4 FLOW CHART OF THE REHABILITATION PROCESS

halfway house program to off-duty residency when he has completed the two week full-time residency program, regardless of other considerations. The superiority of a results-oriented objective can be readily seen when this process-oriented objective is compared to the following results objective:

"In the judgment of an evaluation team made up of the client's counselor, the chief psychologist, the chief social worker, the OIC of the halfway house, the unit commander, and the client himself, the client will be able to remain drug-free outside the halfway house during duty hours while under close supervision."

This kind of results objective provides clear guidelines for making decisions about the client. It provides a criterion for deciding whether he has reached a desired level of rehabilitation. Program staff can then decide whether to allow him to progress to the next phase of rehabilitation with certain specified modifications or limitations, to keep him in the phase that he is currently in, to have him repeat the phase he has just completed or an earlier phase (e.g., repeat detoxification), or to advise his commander that he has failed in rehabilitation efforts and should be considered for discharge.

Figure 5 shows the same flow chart with a set of objectives added for each phase of the rehabilitation process. Adding the objectives to the flow chart in this manner can help to keep all phases of the process oriented toward their objectives. Also, in view of the difficulty of identifying the best rehabilitation modalities and techniques for a given client, the technique of graphically displaying the rehabilitation process in terms of results-oriented objectives can help the rehabilitation staff to select the

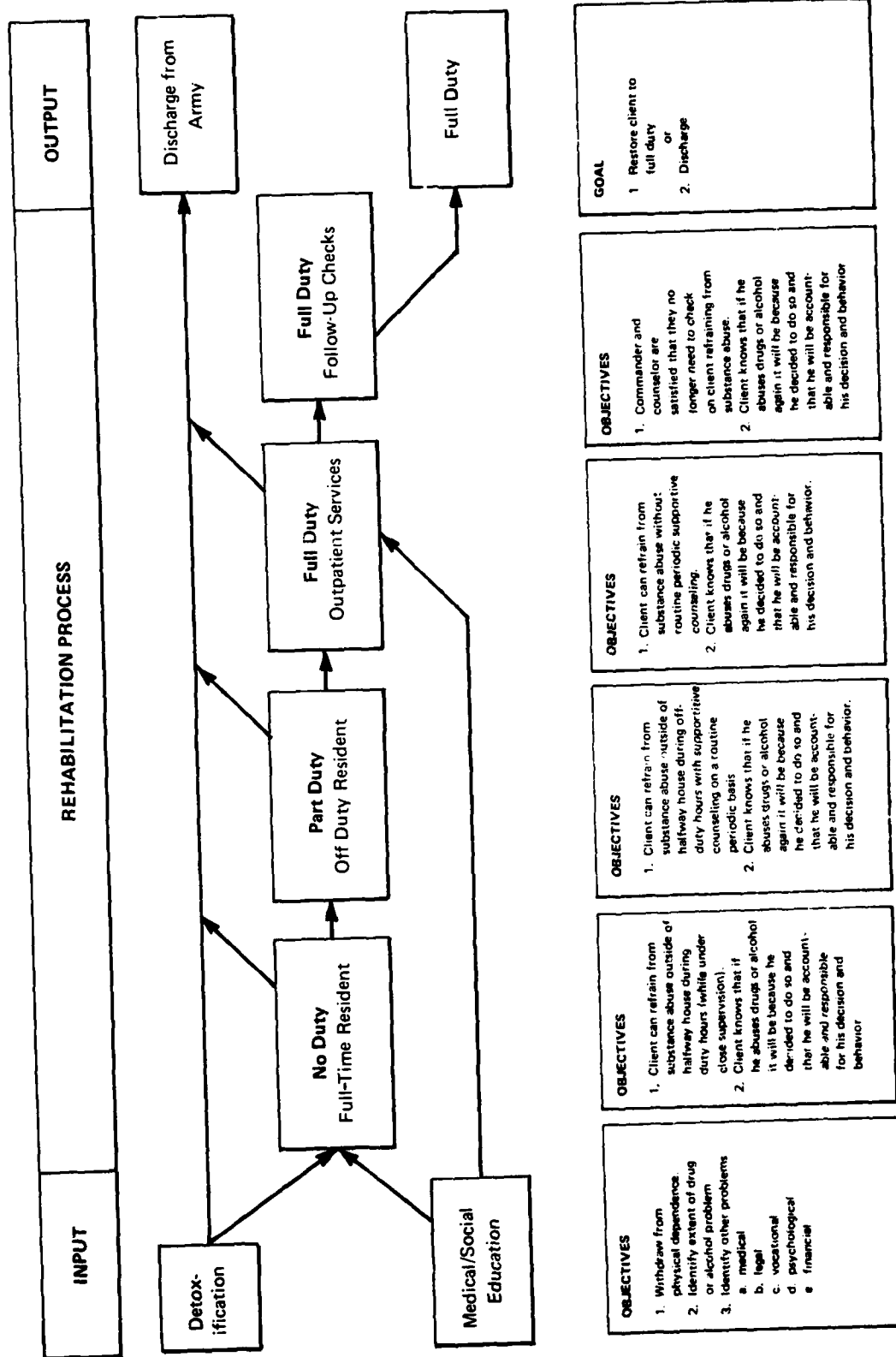


FIGURE 5 FLOW CHART OF THE REHABILITATION PROCESS, WITH OBJECTIVES

activities and modalities which seem best for a given objective at a given phase of the process. For example, if one of the objectives is to have the client understand that his use or non-use of drugs represents a decision he has made, one modality at this stage could be an education program on what a decision is and what goes into making a decision. If another is to get him to make his decision in favor of remaining drug-free while on duty, another modality might be chosen to reduce his incentive to use drugs; for instance, if he feels anxious and tense, sharing these feelings in group therapy may be helpful. The use of a group might also help to meet the first objective: getting the client to recognize that using drugs is his own decision. It is hard for a client to get away with self-justifying rationalizations and blaming others in a group situation, because the other members of the group quickly see what he is doing and point it out to him. Note that, in the example shown in the diagram, each objective is stated as a criterion for graduating to the next phase. The construction of such diagrams can facilitate the decisions on other kinds of program objectives as well.

3. Use of the Halfway House

The ADAPCP can decide whether or not a given drug user or problem drinker will be required to participate in the halfway house program. One issue to keep in mind here is that when the program requires a soldier to go into the halfway house instead of being treated on an out-client basis from the start, the program implicitly assumes a large portion of his responsibility for stopping substance abuse by denying him the opportunity to take drugs. In some cases, this may be counterproductive to getting clients to accept

responsibility for their own behavior. In other cases, however, the client will not yet be capable of assuming responsibility for his own behavior. The ADAPCP's temporary assumption of this responsibility may be the only way to keep him free of substance abuse during the initial rehabilitation period.

The rehabilitation process chart (Figure 5) can be used as a tool for making this and similar decisions. First, each objective is restated in the form of a question and the person or persons (for instance the evaluation team) responsible for answering the question is identified. If their answer is negative, the client needs to participate in that phase of the program. Thus, if the client under consideration cannot remain drug-free outside of the halfway house during duty hours while under close supervision, then he needs to participate in the "no duty, full-time resident" phase of the program.

4. Involvement of Significant Others

Another area of rehabilitation in which options are available to the ADAPCP is that of the degree of involvement of "significant others" in the process. Significant others are those people with whom the client is closely associated and who are importantly involved in his life--his supervisor, commanding officer, first sergeant, roommates, spouse and children, girlfriend, etc. Some civilian programs will refuse to treat a problem drinker unless his spouse also participates in group therapy and individual counseling. While the ADAPCP cannot refuse to treat anyone who is authorized for treatment, it does have the option of strongly encouraging significant others to participate, not necessarily by entering therapy but by assisting

the rehabilitation effort in some way. In fact, when it comes to the participation of other military personnel, the CO may be willing to require it.

As an example of participation by significant others, it is desirable to request the unit commander of each rehabilitation client to provide periodic reports on the client's work performance. Program staff can use the contents of the commanders's report in choosing methods to restore the man to full duty, thereby both improving the rehabilitation process and enlisting the commander's support. Also, the report can be shared with the client as a reality check on his assertions about what happens on duty, as an incentive for improvement, and as a means of identifying specific areas where improvement is most needed. The process will benefit if the commander also participates in making decisions on whether the client is ready to progress from one phase of the program into another.

5. Adding New Modalities

In selecting rehabilitation modalities, the ADAPCP is at first constrained by the modalities its staff is capable of applying at any given time. However, through the setting of results-oriented objectives, and the analysis of these objectives, staff may have decided that they want to try certain modalities which they are not currently competent to use. If these modalities seem important, the ADCO may consider providing training in them as part of the in-service training program. This could be accomplished by sending staff members to outside training programs and having them come back and share what they have learned

with others, or by contracting qualified people to come and provide the training on the post.

Some modalities and techniques may be available in the local civilian community at little or no cost to the program. For example, Alcoholics Anonymous and other self-help programs, as well as many religious organizations, will usually try to provide services for ADAPCP clientele free of charge. The program should not hesitate to avail itself of these opportunities. In addition, the local civilian community may have competent instructors in various meditation techniques and the oriental martial arts (karate, Tai Chi Chuan, Kung Fu, etc.) which may prove to be good substitutes for drug use for some clients.

V. WHAT IS ACTUALLY BEING DONE? MONITORING PROGRAM ACTIVITIES

- *What process and content have been specified for each ADAPCP activity?*
- *What process and content characterize activities that interface with the ADAPCP?*
- *What are the key points to be monitored?*
- *How will (1) personal observation, (2) formal and informal contacts, and (3) standard reporting procedures be used in the monitoring process?*
- *Is the education program being carried out as planned in terms of:*
 - *Target audiences?*
 - *Course content and instructional methods?*
 - *Appropriateness of facilities?*
 - *Competence of instructors?*
- *Are the ADAPCP's community action objectives being met? How well is identification being accomplished by the exemption and referral processes?*
- *Are the steps in the rehabilitation process being followed as planned?*
- *What, if any, changes in client behavior can be observed at each stage, and can inferences be made about program modalities?*
- *Who is receiving rehabilitation, and are there differences among units?*

- *What resources--staff, facilities, and materials and equipment--are allocated to the education and rehabilitation components, and what is their utilization?*
- *What utilization is made of outside resources?*
- *To what extent are civilian agencies in the community serving potential rehabilitation clients?*

This chapter assumes that goals and objectives have been set for the ADAPCP, that they have been translated into specific tasks, that staff have been organized and assigned their responsibilities, and that resources have been allocated. The next step in the management process, and the one requiring the most time on a continuing basis, is monitoring program activities. This can be accomplished partly in person by the ADCO or his representatives and partly through standardized reporting procedures.

A. DESIGNING A MONITORING SYSTEM

A monitoring system serves a number of purposes. For example:

- It helps to determine whether orders are carried out.
Unless those responsible at each level of the ADAPCP have an effective mechanism for determining whether their orders are executed, the program is likely to drift away from its initial design.
- It indicates whether activities are working out as planned.
Since plans are inevitably based on many assumptions, they often go awry. Feedback is needed about key activities so

The forms in Appendix H provide for the inclusion of considerable data on the client's behavior and progress (adjustment, disciplinary actions, drug use, etc.) throughout the rehabilitation process. As changes are observed in the patterns of client progress, they can be investigated to determine, if possible, how they may relate to the program. Indications of who or what caused a change may be found in data on when it occurred or started occurring. (An apparent change in client behavior is suspect, for example, if it is found to coincide with a change in the procedures used to observe behavior.) If the investigation leads to modifications in the program, any further changes can again be studied.

Other items to monitor, as in the case of education, are the recipients of the program and the resources used. If basic demographic data about clients--age, sex, grade, etc.--are maintained by unit, it is possible to compare one unit with another with respect to the types of people involved in the program. Comparisons of units also show which ones are identifying and putting into rehabilitation more clients than others, although the data do not show whether the cause lies in the identification and referral process or simply in the prevalence of drug use or problem drinking in a given unit.

Resources can be identified primarily in terms of staff and time, since facilities are not likely to change appreciably. In monitoring staff, it is important to review positions authorized as well as positions filled. This is so basic that it is often overlooked, but if there are vacancies on the staff of which the ADCO is not aware, staff capabilities will be limited accordingly, as will the services the program can offer.

Staff resources also include the man-hours contributed to the program by individuals and agencies not reporting to the ADCO. More difficult to obtain, but very valuable, is information on the degree to which people eligible for the program but not confirmed as substance abusers are receiving services from civilian agencies in the community.

The monitoring of rehabilitation relies greatly on good communications among the components of the program and between the program and both other agencies on the post and related services in the community. Also, since the drug user or problem drinker may cross paths with anyone on the post, everyone potentially influences the outcome of the rehabilitation effort. Information on how both officers and enlisted men perceive the program and its clients can be quite important. Also, attitudes toward clients can be usefully compared with how the client perceives himself as being treated.

Relationships between program staff and others can be formal or informal as seems appropriate, but their development deserves careful attention. Particularly important are relationships with the leadership structure; the ADCO's responsibilities for the success of his program should be shared by the client's superiors in his unit and by policy makers on the post.

VI. WHAT HAVE WE ACCOMPLISHED? MEASURING RESULTS

- *What does cost/benefit analysis show about the relative effectiveness of program components or strategies, and about the program's overall value to the installation?*
- *How has the education component affected knowledge and attitudes concerning substance abuse, as measured by pre- and post-tests or surveys using experimental and control groups?*
- *How has it affected substance abuse behavior, as measured by surveys, direct observation, and official records?*
- *What does the ratio of confirmed substance abusers to total estimated substance abusers indicate about the effectiveness of the identification component?*
- *How do the incidence and nature of substance abuse, productivity in performance of duties, personal adjustment, and discipline compare for rehabilitation clients before, during, and after the program?*
- *To what extent are former clients retained in the Army?*
- *How do these measures compare for specific rehabilitation modalities?*

This chapter describes ways of determining how well the ADAPCP has achieved its intended results. It also discusses how to relate results to costs, thereby determining how much the program is paying for what it

achieves, and obtaining a quantitative measure of program results to present to others.

A. MEASURING AND ALLOCATING COST

Appendix J describes in detail how to conduct cost/benefit analyses and includes sample forms for recording the costs of each program component. Although this is part of the program monitoring process and aspects of it have been mentioned in the previous chapter, it is discussed here because of its importance in evaluating program results. No matter how well a program meets a given objective, any useful assessment of its results must take into account its costs and the fact that other objectives may also require a share of available dollars.

Like any other program, the ADAPCP competes for scarce resources, including money, time of individuals, and equipment. Within the program, each component competes to some extent with the others. By keeping track of the costs of both personnel and equipment, the ADCO and his staff have a common framework to examine the program and all its elements. Further, those at a higher level who are concerned with allocating costs can make their own intelligent decisions, based on data from program staff, as to the priorities among competing demands for budget.

Costs include considerably more than the cash budget allocated to the ADAPCP. This cash budget usually covers only such typically minor expenses as equipment, books, and the costs of travel to professional conventions and other travel for professional and training purposes,

while actual costs include, for example, the salaries of all staff members. Also included should be costs borne by other agencies for services (staff time, etc.) which they provide to the program at no charge.

Since the ADAPCP has two main purposes, one related to alcohol and the other to drugs, it is advisable to allocate costs between them when carrying out cost/benefit analyses.

B. MEASURING RESULTS OF EDUCATION/PREVENTION

Each of the target audiences identified for alcohol and drug education will have been exposed to a program aimed at one or more of the following basic objectives:

- (1) Increasing knowledge.
- (2) Changing attitudes.
- (3) Changing motor behavior (what people do).

Within each overall objective, specific operational objectives have been established as discussed in Appendix E, stating exactly what results are to be achieved, during what time frame, in terms that permit subsequent measurement of those results. This makes possible the use of anonymous pre- and post-tests to measure what the program has accomplished in the way of increasing knowledge or changing attitudes. A pre-test is a test given to a target population, or a sample from it, before exposure of its members to the program. The post-test is the same kind of test, or one which has been calibrated against the pre-test, given after a group has been exposed. Appendix I discusses in detail questions of experimental design, for instance, whether the pre-test and post-test should both be given to the same group, or whether each

should be given to both an experimental group and a control group. When the experimental design is properly set up, the difference in test scores between the pre-test and the post-test is a proper measure of the effect of the program.

Various means can be used to measure the effect of education programs which seek to influence behavior--that is, to affect the amount or type of substance abuse. The first is a survey, again given both before and after exposure. With the proper experimental design, it is possible to show, as in Table 3, whether those people exposed to the program had a significantly smaller increase in drug use than those not exposed. If the increase was significantly smaller, the program has clearly had a preventive effect on drug use (see the top portion of Table 3). The same design can test whether the program had corrective effect--that is, whether it cut down on the number of users in the experimental group while they increased or remained constant in the control group. (The lower portion of Table 3 illustrates such a situation.)

Data as shown in Table 3 can also be gathered by observation; for instance, the number of people in the experimental group's barracks observed (by someone who is unobtrusive and has no law enforcement responsibilities) smoking marijuana can be compared with those in the control group's barracks, with the same time periods and exposure to education as used for the pre- and post-tests. Note that using one barracks for the experimental group and another for the control violates the principle of random sampling discussed in Appendix D. It should be done only if baseline data can be obtained prior to the experiment showing that background characteristics and patterns of alcohol/drug use are closely matched in the two groups.

TABLE 3
EXAMPLES OF RESULTS, BASED ON ANONYMOUS SURVEYS,
OF SUCCESSFUL EDUCATION PROGRAMS

A. Success in preventing further spread of drug use:

<u>Group</u>	<u>Proportion using a given drug, e.g., heroin</u>		
	<u>January</u>	<u>Exposure to Education</u>	<u>June</u>
Experimental	8%	Yes	8%
Control	8%	No	13%

B. Success in correcting use of a drug:

<u>Group</u>	<u>Proportion using a given drug, e.g., heroin</u>		
	<u>January</u>	<u>Exposure to Education</u>	<u>June</u>
Experimental	8%	Yes	3%
Control	8%	No	10%

Needless to say, observation should be as closely standardized and controlled as are the conditions under which anonymous surveys take place. For example, use of a marijuana smoker as the observer in one barracks, but a non-user in the other, could introduce observer bias in such a way as to make the data gathered useless. Other factors which need to be controlled include time of day and definition of a valid observation ("How do you know he was smoking marijuana?").

Records reviews can achieve the same purpose, but have to be approached very cautiously, bearing in mind the primary (original) purpose for which the records were kept and how people come to be entered onto them. For example, one cannot necessarily conclude that arrest frequencies are one-to-one indicators of drug use. The number

of arrests for drug use will be affected by the number of people engaged in law enforcement and the instructions they are given as to which offenses to pursue most diligently. They will be affected by changes in the legal definitions of offenses. They may be subject to severe temporary transients; for example, there may be no arrests for cocaine use for many months, while law enforcement personnel are carefully building up a case against a network of users, and many arrests during a single day when the trap is sprung. This should not lead anyone to conclude that cocaine use was heavier on that day than during the preceding months.

So long as caution is used in drawing inferences from records, they may well provide a valuable addition to survey results and observation. Appendix I lists some specific data from records which could be useful.

C. MEASURING RESULTS OF IDENTIFICATION

The primary objective of the identification component of the program is likely to be positive identification of a major portion of the drug users and problem drinkers on the post. In order to measure the effectiveness of this effort, data are needed to form a numerator and a denominator.

The numerator consists of the number of confirmed substance abusers, recorded separately by substance. This can be ascertained by summing the number of abusers of that substance that have been identified during each month, cumulatively, in a year. If a person is identified as an abuser of two substances, he should be counted under both of them.

The denominator consists of the total number of people on the post who are probably abusing that substance, as indicated by anonymous surveys or population statistics. Here again, the same person can count as part of the denominator for more than one substance.

The higher the proportion of confirmed abusers, the more successful the identification component of the program has been. Conversely, a low proportion is a danger signal. If it appears that only one percent of the abusers of a particular substance on the post has been confirmed, there is ample indication that the identification component needs strengthening. Obviously, an uncorrected failure in the identification component will lead to a corresponding failure in the rehabilitation component.

D. MEASURING RESULTS OF REHABILITATION

It is probably fair to say that rehabilitation of drug users and problem drinkers is the most important component of the program. It has probably been allocated more staff than has any other component. Its target group consists of people who are highly visible to the command and leadership structures, having been confirmed as substance abusers. Indeed, the purpose of the identification component is essentially to ensure that rehabilitation reaches those who need it.

The ADCO is under considerable obligation, then, to show results for the resources allocated to rehabilitation. This responsibility extends to clients and prospective clients who will be helped by knowing that their participation is not a waste of time. The installation's Commanding Officer wants assurance that funds under his control are not

being wasted. Unit commanders of program clients may need to be convinced that ADAPCP rehabilitation of their troops is preferable to criminal punishment, to automatic discharge of drug users and problem drinkers, or to attempts to handle the problem entirely within the unit. Commanders can be shown that the training investment in soldiers is forfeited if they are discharged; that the unit does not have the facilities or trained personnel to handle problem drinkers and drug users; and that Army policy and current professional opinion concur in the view that problem drinking and drug use are not amenable to control by the criminal justice process.

Finally, the importance of the rehabilitation component in the program justifies careful attention to obtaining good measures of its effects. As discussed in the last chapter, this includes not only its overall effects but also the effects of specific stages in the rehabilitation process. Only in this way is it possible to begin addressing the problem of evaluating different treatment modalities.

Measures that can be used in evaluating rehabilitation are discussed primarily in Appendix K; however, the program monitoring forms provided in Appendix H provide for the entry of data on results throughout the course of rehabilitation. Depending on the objectives initially set for the program, results may be measured in terms of:

- Improvements in the incidence or nature of substance abuse from before rehabilitation, to specified stages of the rehabilitation process, to a designated later time.

- Increases in productivity, the ability of clients to perform their military duties.
- Retention in the Army of clients following rehabilitation.
- Improvements in personal adjustment, relations both with peers and with those in authority.
- Improvements in performance related to military discipline.

Rehabilitation, unlike education and prevention, does not permit the use of control groups since the ADAPCP is morally and legally required to provide rehabilitation to all confirmed substance abusers. The only ways, then, to determine the results of rehabilitation are (1) to compare the above measures for the same group of abusers before, during, and after rehabilitation, and (2) to obtain separate measures for clients exposed to different treatment modalities, thereby comparing the effectiveness of the modalities. As discussed in Appendix H and Appendix K, the data can be gathered from the client himself at times beginning with his entry into rehabilitation, from the military superiors of the clients, and from official records, such as those covering disciplinary actions.

Finally, it is especially useful to analyze the costs and benefits of rehabilitation (see Appendix J). The resulting figures can provide a strong response to the recurrent question of whether the Army would not simply be better off to discharge all confirmed substance abusers.

VII. IMPROVING THE PROGRAM

- *What does a review of the management cycle reveal about?*
 - *The appropriateness of program objectives?*
 - *The appropriateness of program strategies?*
 - *The appropriateness of monitoring methods and results?*
 - *The appropriateness of evaluation methods?*
 - *The achievement of program objectives and the reasons for successes and failures?*
- *What are the problem areas in either program design or the management process, and what options are available for improvement?*
- *What recommendations for improvement will be made to superiors?*

Previous chapters of this manual have discussed the planning of an Alcohol and Drug Abuse Prevention and Control Program, the use of management information to ensure that the plans are put into effect, and the measurement of program results. This chapter discusses how the steps in the management process can be reviewed to shed light on why the program has or has not achieved its objectives and what actions could be taken to improve the program. The checklist in Section A gives examples of questions whose answers may help to pinpoint the reasons for program successes or failures. Additional questions will be applicable

to any individual program; a general discussion like this cannot cover all possible factors affecting the observed results of an ADAPCP.

A. WHY DO MEASURED RESULTS MATCH OR FAIL TO MATCH OBJECTIVES?

One year is probably a good time period for a single, full iteration of the management cycle. Although ADAPCP staff will be working all along to evaluate and improve elements of the program, a periodic, comprehensive review places each element in the context of the whole, permits a systematic comparison of results with objectives, and provides a basis for determining what, if any, changes should be made in either program design or the management process.

Whether or not measured results show that objectives were achieved, the ADCO might ask himself and his staff questions such as the following. It might also be desirable to seek the participation of the Commanding Officer in these discussions.

1. Appropriateness of Objectives

- Were the right objectives established?
- Were they based on adequate need assessments?
- Were unwarranted assumptions made about needs?
- Were the objectives feasible, in terms of:
 - The stubbornness and complexity of the problem?
 - The resources available?
 - Critical cooperation from other parties?
- Were the objectives sufficiently clear to provide guidance for everyone involved in achieving them?

- Did the objectives, or programs arising out of them, conflict with other objectives or programs on the post, and did this conflict prevent one or both sets of objectives/programs from being fully realized?
- Were objectives for different components of the program supportive of one another, or at least consistent with one another?

2. Appropriateness of Strategies

- Given the objectives, was sufficient attention paid to identifying the best strategies for achieving them?
- Were these strategies feasible, given the number and qualifications of available staff?
- Were the strategies chosen communicated adequately to the staff?
- Did any external constraints prevent the staff from following the designated strategies? (For example, did another agency fail to provide the program with the staff time, facilities, or other resources expected from it?)

3. Appropriateness of Monitoring Methods and Results

- Were the right monitoring methods established?
- Was monitoring information in fact provided?
- Was information provided at the necessary level of detail?
- Was information provided on a timely basis?
- Was the information accurate?
- If not, why not? (For example, was it because of self-serving motivations of those who provided it? Because instructions for furnishing information were not sufficiently precise? Because it was not possible to provide more accurate information?)
- Did the feedback obtained by monitoring indicate that the prescribed methods were being used?
- If not, was this because of internal constraints (such as staff limitations of time, numbers, or training) or because of external constraints (such as failure of clients to report for scheduled counseling sessions)?
- Did the ADCO review monitoring results and act upon them?

4. Appropriateness of Evaluation Methods

- Were program results measured in terms that corresponded to program objectives?
- Were reliable methods used to measure results?
- Were costs properly identified and related to results?

5. Achievement of Objectives

- Did the evaluation indicate that the program had achieved the objectives set out for it? At acceptable costs?
- What do the answers to the above questions suggest about why or why not?

B. WHAT IMPROVEMENTS SHOULD BE MADE?

The above review process should help to identify trouble spots in the program or--if it achieved its objectives--to identify opportunities to do even better. The ADCO and his staff are then in a position to decide how to improve the program by changing objectives, strategies, procedures for monitoring or for measuring results, or a combination of these. This, then, produces an improved management plan.

When all the elements of the management process are reviewed together, it is possible to see how they fit and how adjustments in one will affect the others. For example, program staff may find that certain original objectives were unrealistic for the resources available. Possible solutions are to set less ambitious objectives, or to obtain increased resources. The management process enables staff to see how they could go about either option--which objectives could be lowered, what resources could be requested--and how either choice would affect the program and monitoring systems. This provides not only a firm basis for making a choice, but also clear backup to use in justifying the recommended choice to superiors. To take another example, it may become apparent that certain designated strategies were not properly implemented. An assessment

of why they were not implemented will enable the ADCO to decide whether it is better to change the prescribed strategies or to take steps to ensure that the designated strategies are in fact applied in the future.

C. SUMMARY

The management process helps to permit apparent program results to be traced to their causes. By reconsidering program objectives (Chapter III), the choice of strategies (Chapter IV), the degree to which strategies were implemented and reliability of the monitoring methods used to make this determination (Chapter V), and the results achieved and reliability of the measurements used (Chapter VI), the ADCO and his staff can identify changes that will have a high probability of strengthening the program. The objectives-strategies-monitoring-results cycle then begins anew as illustrated in Figure 1 early in this manual.